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<http://dx.doi.org/doi:10.21954/ou.ro.0000e2de>

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# **THE ROLE OF CLINICAL PSYCHOLOGY FOR HOMELESS PEOPLE**

**A thesis submitted in partial fulfilment of the requirements of the  
Open University for the degree of Doctor of Clinical Psychology**

**NOVEMBER 2000**

**20, 000 words (approximately)**

**SALOMONS  
CANTERBURY CHRIST CHURCH UNIVERSITY COLLEGE**

**Award Date: 20 September  
2000**

## Acknowledgements

I would like to thank all of the homeless men and the Clinical Psychologists who agreed to take part in this study. Your kindness and generosity of your time made this possible.

Special thanks go to the hostel staff, the inner city day centre mental health team and especially the Manager and staff of the rural day centre/night shelter who looked after me well and helped me to recruit the participants. Along the way I discussed this study with a great number of Voluntary Sector and Statutory Staff, none of whom are forgotten.

I would sincerely like to thank Dr Susan Holttum (academic supervisor, South Thames Clinical Psychology Training Scheme, Salomons) for her excellent supervision and support that went above and beyond the course of duty. Living proof that there is a role for clinical psychology came from Patricia Potter (clinical supervisor, Clinical Psychologist at HHELP, London) whom I would like to thank for helping me to bridge the academic-clinical divide.

For showing me that 'Headology' is a worthwhile profession, I give credit to Terry Pratchett and Granny Weatherwax, truly an inspiration. Nicolette, my own living inspirational personification, thank you.

Finally, and most importantly, I would like to thank Georgie my one true love (♫ me and you ♫, ♫ you and me ♫). To my family and friends who have always supported me and believed I could do it, Mum, Dad, Christian and Damian, this is for you, Wayne, Topsy and Tim.

## **Abstract**

Recent research has suggested that mental health problems are over-represented in the homeless population. Currently mental health services are under-utilised by this group in proportion to need. It is often assumed that psychological intervention is unlikely to be helpful with a client group where basic needs are often not met.

The Transtheoretical Model of Change is used as a framework to describe the complex, dynamic processes that are likely to impact on a homeless person with mental health problems' ability to seek help for their mental health difficulties. This model is also applied to services. The empirical evidence for Maslow's Hierarchy of Needs as a help or hindrance to help-seeking behaviour is examined. This study asked homeless people to identify their own needs and explored current working practices of the few clinical psychologists who work with them directly.

Interpretative phenomenological analysis (IPA) was used to explore the role for clinical psychology for homeless people. A pilot study was conducted. In the main study, nine men from two day centres/night shelters (one rural and one inner city) were recruited opportunistically. Five clinical psychologists working within the homelessness field were recruited.

Psychopathology of the homeless participants was measured using the GHQ-12 and BPRS. Within a user-designed approach a semi-structured interview was developed for the main study from the pilot study.

The results indicated that this sample of homeless people with significant mental health problems identified a need for clinical psychology intervention and this was supported by the views of the clinical psychologists whom already worked in the field. Implications in terms of the level and type of clinical psychology interventions best suited to working with this client group are discussed.

This study is timely, and the first in the UK to explore the role of clinical psychology for homeless people.

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# **Chapter one**

## **INTRODUCTION**

# **1. Introduction**

This study will begin with a review of the literature on homelessness and mental health. Then, drawing upon the Transtheoretical Model of Change (TTM; Prochaska & Prochaska, 1999) as a framework, barriers to the homeless with mental health problems engaging with mental health services in general, and clinical psychology services in particular will be explored. This framework will also be applied to clinical psychology services, since they may have to change themselves in order to enhance the possibility of the homeless engaging with them. The role of self-efficacy within individuals and organisations (Bandura, 1999) as a potential help or hindrance to engagement will be highlighted. Because of the lack of ways to fulfil basic survival needs associated with being homeless (that is, shelter at the minimum) the empirical evidence for Maslow's (1968, 1987) Hierarchy of Needs as a barrier to engagement will be examined.

This study is an exploration of the mental health needs of the homeless from their own perspective and that of clinical psychologists who work with this population. Connections to existing psychological theory, particularly the models mentioned above, will be made.

## **1.1 The Homeless Literature**

### **1.1.1 Definitions of Homelessness**

There are many varieties of homeless individuals and many definitions of homelessness. The word 'homeless' may be used as a category, as a description of one of many complex needs, as a legal definition or as a self-ascription relating to the quality of an individual's accommodation (Bhugra, 1998). At present, the currently enforced legal definition of the

statutory homeless, as stated in the Housing Act 1985 (NHS: Health Advisory Service, 1995, p.22) is if they and those members of their family with whom they normally live:

- Have no accommodation that they are entitled to occupy;
- Have a home but are unable to gain entry to it;
- Have a home but are in danger of violence from someone living there;
- Has accommodation that is moveable (e.g. a caravan or a houseboat) but has nowhere to place it.

In practice, people deemed by local authorities to be in priority need for housing under this Act are households with dependent children, pregnant women and people who qualify by reason of physical or mental health. This leaves a large group of people – often described as the ‘single’ homeless – un-provided for. The British government uses the term “roofless” which excludes most homeless people who do not actually sleep rough, whilst the NHS uses the term ‘NFA’ (no fixed abode) which can include (depending on which Health Authority you are in) all people in hostels, Bed and Breakfast’s and sleeping on other people’s floors (Singh, Melzer, Holbrey, Meddings & Shepherd, 1992).

Some of these definitional problems are avoided in the current study that focuses on single homeless men in two day centres/night shelters who have been rough sleepers.

Consequently the study does not claim to be relevant to the homeless population as a whole. In discussing previous research, reference will be made where possible to the subsection of the homeless population under consideration. Most attention will focus on single homeless night shelter users and rough sleepers.

### **1.1.2 Prevalence of homelessness in the UK**

It is virtually impossible to give an accurate figure on the numbers of homeless people in the UK (Susser, Conover & Struening, 1990). The single homeless are not subject to any form of centralised monitoring. Problems with definitions and methodologies for enumeration make it difficult to ascertain precisely the level of homelessness, although Scott (1993) estimated that there are between one and two million homeless people. This estimate suggests that the UK has the second highest level of homelessness per thousand of the population in Europe (Daly, 1996). The Office of Population Censuses and Surveys (OPCS, 1991) reported an estimated 2, 703 rough sleepers in England and Wales. Of these, 47% (1,275) were in London. One of the key aims of the Government's health strategy for England is to improve the health of the worst off in society (DOH, 1999a). The Social Exclusion Unit (SEU) set up in 1997, aims to reduce rough sleeping by two thirds by 2002 (SEU, 1998). Bhugra (1998) suggests, however, that the available figures should generally be viewed as under-estimates because of the enumeration difficulties.

### **1.1.3 Homelessness and gender**

Many fewer women are homeless than men. Those women who are homeless are much more likely to be staying in private sector rented accommodation and also tend to be part of two-parent or single-parent families (Gill, Meltzer, Hinds, & Petticrew, 1996). Nine in ten homeless people using night shelters or sleeping rough were male (OPCS, 1991) and the average life expectancy for rough sleepers is just 42 years (Shelter, 1998). The OPCS survey also found that very few non-White people were rough sleepers. However, there are likely to be specific problems for non-native and minority populations, many of whom may be refugees. It is unlikely that the present study will make any assumptions or conclusions based on differing ethnicity, which is outside the present scope.

#### **1.1.4 Causes of homelessness**

The link between homelessness and lack of money or housing is obvious. Changes in the employment market leading to a relative lack of unskilled employment and changes in the housing market such as the sale of council stock (London Research Centre, 1992) have led to a lack of affordable housing and contribute towards homelessness. Statistics from the Department of the Environment, Transport and the Regions (DETR, 2000) show that in the first quarter of this year reasons for homelessness given to local authorities were:

- That parents, relatives or friends were no longer willing to accommodate them (30%);
- Breakdown of a relationship with a partner (23%);
- The end of a short hold tenancy (14%); and
- Mortgage arrears (4%).

The single most common reason given for the first episode of rough sleeping was relationship breakdown either with parents or partner (SEU, 1998). Other reasons included widowhood, eviction, redundancy and mental illness. Care leavers, those leaving prisons and the armed forces were all significantly over-represented in the rough sleeping population suggesting that these people are particularly vulnerable to homelessness.

Along with mental illness, substance misuse is also thought to be a critical factor in the generation and perpetuation of homelessness (North, Pollio, Thompson, Ricci, Smith, & Spitznagel, 1997). Drinking-associated problems may raise the threshold for 'vulnerability', reduce the protection afforded by social networks against both homelessness and 'vulnerability' in general, increase the deleterious impact of disaffiliation, and spur complicating mental health problems (Sosin & Bruni, 1997). However, individual problems such as mental illness and substance abuse do not by themselves cause lack of affordable

housing. Rather they are likely to lead to a vulnerability to homelessness (Shinn, 1992; Brandon, 1998), perhaps through loss/lack of employment and/or breakdown of social ties.

Many studies have found a history of childhood abuse in populations of homeless people (Kiesler, C.A., 1991; Scott, 1993; Shinn, 1992; Sumerlin, 1999; Toro, Bellavia, Daeschler, Owens, Wall, Passero & Thomas, 1995). Sumerlin (1999) examined patterns of homelessness against histories of childhood abuse in a sample of rough sleepers and found that homeless men who experienced abuse as a child had more episodes of homelessness than those who had not experienced abuse. Sumerlin speculated that childhood abuse influences the need for love and belongingness as an adult, (i.e. the need for trusting, accepting relationships), and prepares the child for adult homelessness as their capacity to fulfil this need has been damaged by the abuse. Although necessarily retrospective, case histories supported the findings that feelings of not belonging in childhood were preparatory for chronic homelessness.

In conclusion, the origins of any individual's homelessness are complex. Many factors are associated with the cause, maintenance and consequence of homelessness, although few factors are proven to be causally linked beyond the individual experience. Homelessness is the result of a dynamic process, influenced not only by individual risk factors but also by systemic forces that are at least of equal importance in increasing or maintaining residential instability.

#### **1.1.5 Homelessness and mental health**

It is difficult to obtain accurate figures on mental illness within the homeless population because the sample sizes and methods of determining psychiatric disorder have varied considerably (Sims & Victor, 1999). Figures are necessarily dependent on the approach or

definitions adopted by different researchers. In addition, when assessing psychiatric morbidity clinicians and/or researchers need to be aware that homelessness in itself may lead to a diagnosis of a mental health problem, rather than the mental illness itself. For example if a homeless person is unkempt and withdrawn this might signify a lack of resources (i.e. nowhere to wash) and an adaptive coping strategy (e.g. keeping potentially risky people away from themselves) rather than evidence of negative symptoms of schizophrenia.

Nevertheless, many different studies have reported higher than normal incidences of mental health problems in the homeless. Recent research has found that mental health problems are over-represented in the homeless population (Bines, 1994; Craig & Timms, 1992; Gill et al.; Scott, 1993). Sims & Victor (1999) found that statutorily homeless people experienced twice the rate of neurotic disorder than those in private households. Bines (1994) found that mental health problems (defined as depression, anxiety and 'nerves') were eight times as high amongst hostel and B&B residents and eleven times as high amongst rough sleepers than in the general population. In addition one in eight people in hostels and B&B's, one in five people at Day Centres and one in six people at soup runs had been in a psychiatric hospital at some time in the past.

According to Scott's (1993) review of homelessness and mental illness, significant mental illness was present in thirty-fifty per cent of the homeless where functional psychoses predominated and co-morbidity of mental illness and substance abuse occurred in twenty per cent, much higher than in the general population (Bhugra, 1998). Research has consistently demonstrated higher rates of psychiatric disorder amongst rough sleepers and night shelter users who in particular experienced an even higher prevalence of psychosis and were the most likely to have ever stayed in a psychiatric hospital (Gill et al., 1996).



### **1.1.6 Causes of mental illness in the homeless population**

Explanations for the increased psychiatric morbidity of homeless people include; histories of child abuse (Sumerlin, 1999); inadequate housing (Connelly & Crown, 1994; Faculty of Public Health Medicine, 1998); poverty (Breakey & Fischer, 1995); inadequate social support (Lehman, Kernan, DeForge & Dixon, 1995; Meltzer, 1995; Wu & Serper); infrequent use of primary care services (Health Education Authority, 1999); stressful life events such as long-term physical illness and contact with the police (Meltzer, 1995); exposure to violence (Fitzpatrick, LaGory & Ritchey, 1999) and poor coping skills (Craig, Bayliss, Klein, Manning & Reader, 1995).

Few studies have included appropriate comparison groups of non-homeless persons. Existing studies generally find the homeless to be deviant on most dimensions when compared with general norms. These studies often state or imply that the deviations observed are related to homelessness, but the deviations may be to do with other factors such as poverty (Toro et al., 1995).

This myriad of explanations only provide partial indications of how and why a person becomes mentally ill, homeless or both. Homeless people are part of a heterogeneous group (Brandon, 1998) and therefore generalisations are not always appropriate.

### **1.1.7 Summary of literature on homelessness and mental health**

Currently there are a large number of homeless people in the UK. Prevalence studies have shown that homeless people experience greater psychiatric morbidity and co-morbidity of substance abuse than the general population. A review of the literature found little attempt of psychological intervention for this particular client group, however homelessness was

defined. This seems surprising, given that the alleviation of mental distress can be thought of as a core function for clinical psychology.

As the homeless literature is mostly epidemiological and does not clearly define a role for clinical psychology for the homeless with mental health problems, it is necessary to turn to the more general literatures on how people acquire a mental health service and the potential difficulties when seeking help.

## **1.2 Help-seeking behaviour**

The most usual assumption made about people entering a psychology service is that they are seeking help. The decision to seek help is a complex one involving the individual or those around them assessing their problems, their significance and the likely impact of the sought after help. How a mental health need is identified is likely to be dependent on an individual's personal history, personality disposition or traits, interpersonal relationships and within the wider societal context. Here, engaging (or not) with a mental health service will be described as a help-seeking behaviour (or absence of a help-seeking behaviour).

### **1.2.1 The Transtheoretical Model of Change**

In the Transtheoretical Model of Change (TTM; Prochaska & Prochaska, 1999) seeking professional help is one step along the path to behaviour change. This model will also be applied to organisational (or service level) behaviour. Some of the potential barriers to change that are most likely to affect the homeless with mental health problems are highlighted.

The Transtheoretical Model (TTM) of change is a social cognition model developed to explain motivation to change behaviour. Help-seeking can be seen as part of that change

process, since it could be taken to indicate recognition of the need to change. The TTM emerged from research on how people change on their own as well as how people change within therapy. People with anxiety, depression, alcohol abuse and psychosis are amongst the wide variety of groups this model has been successfully applied to (Beitman, Beck, Carter, Davidson & Maddock, 1994; DiClemente & Hughes, 1990; McConaughy, Prochaska & Velicier, 1989; Prochaska, Rossi & Wilcox, 1991).

The TTM states that for any particular change people move through a series of stages. The changes referred to here are intentional changes, in which individuals apply psychological processes to improve their own psychological functioning, including overt behaviours and covert experiences. These stages are identified as precontemplation, contemplation, preparation, action and maintenance. At each stage different processes are utilised to support the changes, for example consciousness raising (being aware of a need or problem) in the first stages of change and maintaining helping relationships in the latter stages of change. Movement across the stages is dependent on decisional balance and perceived self-efficacy. Decisional balance (Janis & Mann, 1977) is a cognitive assessment of the relative merits of the pros and cons of the behaviour, while self-efficacy is the belief in one's capability to perform the behaviour *and* to achieve a desired outcome (Bandura, 1999).

There have been some criticisms of the Stage of Change Model, claiming that there is insufficient evidence of distinct stages, nevertheless there is evidence that people can be at different levels of 'readiness to change' (Rollnick, Heather, Gold & Hall, 1992; Budd & Rollnick, 1996). In this study the phrase 'precontemplation' is considered appropriate for referring to individuals or organisations that are not yet ready to change.

Social cognition models are generally criticised for being individualistic; implying that change is the responsibility of the individual. In particular, self-efficacy has traditionally been conceptualised as a concern for the individual. However, people do not live their lives in isolation. They work together to produce outcomes that they cannot perform on their own, in groups or organisations. Individuals approaching services are likely to do so because they cannot solve their problem for themselves. People's shared beliefs in their collective efficacy to produce desired outcomes are a crucial ingredient of a collective agency (or efficacy), (Bandura, 1999). Collective efficacy is not simply the sum of individual efficacy beliefs, but results from the interactive dynamic relationships of the group's members. This might be the 'group' of the client and service provider(s), or the 'group' of the service provider and service. It has been shown that the stronger the belief people hold about their collective capabilities the more they actually achieve (Bandura, 1993; Little & Madigan, 1994; Prussia & Kinicki, 1996). This implies that service providers within organisations such as the NHS, need to perceive themselves as part of an efficacious service in order to give effective help, and that this is just as important as individual self-efficacy.

The TTM states that dependent on the stage of change they are in, people (or services) don't change because they can't, don't want to, don't know how to or don't know what to change (Prochaska & Prochaska, 1999). However, people may be able to change when they progress gradually and when they apply processes that are appropriate to their current state of readiness to change.

Using this framework, the question of what is the role of psychology for homeless people, who we know to experience mental distress more than the general population, becomes the practical question of how do service providers encourage precontemplators to move on or become more ready to change. The advantage is that levels of intervention can be

identified for the individual, the service providers and the organisations that they represent dependent on the level of readiness they are in.

### **1.2.2 Why homeless people may be viewed as 'precontemplators'**

Two possibilities why homeless people under-utilise mental health services (Bhugra, 1998; North, 1994) are that they do not seek help and/or that services are not sufficiently accessible to them. Using this model there are a number of processes at both individual and wider societal levels that are likely to maintain the homeless mentally ill individual in precontemplation, thus maintaining a barrier to engagement with mental health services.

### **1.2.3 Individual reasons for remaining in precontemplation**

In the precontemplation stage as defined by Prochaska & Prochaska (1999), people (or services) are not intending to change their behaviour in the foreseeable future and/or *can't* change because of a number of factors. They may be unaware that their behaviours are problems or be in this stage because of defensiveness, for example in denial about their behaviour or they perceive that others need to change, not themselves, sometimes a characteristic of paranoid or psychopathic personalities. Precontemplators may also be demoralised about their capacity to change (i.e. low self-efficacy) and therefore don't even want to think about change. Ignorance, defensiveness and demoralisation are major barriers to being able to change and can be particularly self-defeating because they can make precontemplators resistant to outside help that can facilitate change.

Bearing in mind the traumatic history of many homeless people, their capacity to engage may be impaired. Indeed, Bentley (1997) found that homeless people felt too vulnerable to talk openly about their feelings and protected themselves psychologically by 'bottling up' or only confiding in one person.

#### **1.2.4 Service provision, social exclusion and discrimination as maintaining the precontemplation stage of change**

Although the current Government has set an agenda of providing high quality, equitable mental health services (DOH, 1998; DOH, 1999b), generally services provided for homeless people who have mental health problems are poor. Services have been shown to be scarce, inaccessible, inappropriate and ill equipped to deal with the complex needs this client group typically have (Bhugra, 1998). They receive very little planned input from services at discharge or follow-up and are significantly less likely to be offered outpatient appointments than the general psychiatric population (Singh et al., 1992).

A body of literature provides evidence of social exclusion and discrimination faced by users of mental health services in many spheres of life (Sayce, 1998). Meddings & Levey (2000) comment that whilst there have been numerous studies of rejecting attitudes towards people with mental health problems (Levey & Howells, 1995; Trutte, Tefft & Segall, 1989; Brockington, Hall, Levings & Murphy, 1993; Repper, Sayce & Strong, 1997) attitudes towards homeless people are rarely examined.

Homeless people often meet with hostility and coldness from staff who do not understand their problems (NHS: Health Advisory Service, 1995). Meddings & Levey (2000) found that in a hostel for homeless people, positive staff attitudes were associated with less punitive, more positive management strategies and more talking responses. Conversely, staff with negative attitudes about the client group that they serve are more likely to give poorer medical care (Marteau & Riordan, 1992; Brewin, 1984). Bhugra (1998) found that discrimination negatively affects the chances of homeless mentally ill people seeking help and accepting help if offered.

Attitudes towards homeless people, especially regarding responsibility for their predicament, could explain why people of no fixed abode receive poorer standards of care (Meddings & Levey, 2000).

It seems reasonable to conclude that mentally ill individuals who also experience homelessness endure a double jeopardy of discrimination and negative attitudes towards themselves. Service provision is poor or inaccessible and it is unreasonable to expect users to change their attitudes about services when they encounter prejudiced behaviour from the service, reflecting the wider general public view. It may be that they do attempt to engage services, but find entry into the health care system a difficult and daunting prospect.

### **1.3 Barriers to accessing mental health services**

If services are ignorant, defensive or demoralised about working with the homeless, or do not perceive themselves as efficacious, then it is unlikely that an effective service, if any, will be offered. When the author began to explore the potential role for clinical psychology, a general theme emerged from the majority of the discussions with workers in the field of homelessness. Both psychologists and non-psychologists discussed the importance of the homeless mentally ill person having their basic needs such as shelter, food and warmth met, before a psychological intervention should be attempted or had some potential for 'success'. Only one clinical psychologist (who worked nine sessions a week in a team for the homeless mentally ill) described a role for psychology before this 'point of entry'. This was in terms of helping people getting to the point where they could actually have their basic needs met as a way of preparing for further psychological intervention.

As this theme of 'homeless people having to have their basic needs met before a psychological intervention' kept coming up, the author began to think of Maslow's Hierarchy

of Needs (1968, 1987), a motivational theory of how people fulfil 'needs' which are necessary to 'good' psychological health. Beliefs and attitudes based either consciously or unconsciously on this idea may well be prevalent amongst mental health workers. The empirical basis for this will be explored, as these beliefs may in themselves be a means to exclude homeless people from psychological services, maintaining the stage of precontemplation for individuals and services.

### **1.3.1 Maslow's Hierarchy of Needs**

Maslow's (1968, 1987) 'Hierarchy of Needs' is a theory of motivation that attempts to explain why people behave in the ways that they do. The theory involves a hierarchical structure of five basic needs, briefly:

1. **Physiological** – including acquiring food, drink, oxygen, temperature regulation, elimination, rest, activity and sex that are needed for physical/biological survival.
2. **Safety** – including protection from potentially dangerous objects or situations (e.g. the elements/physical illness). The threat is both physical and psychological (e.g. fear of the unknown).
3. **Love and belongingness** – Receiving and giving love and affection, trust and acceptance, being part of a group.
4. **Esteem** – respect of others and self-respect, including a sense of competence.
5. **Self-actualisation** – realising your full potential, becoming everything one is capable of becoming.

The function of these needs are to ensure survival by satisfying these basic physical and psychological needs and to promote the person's self-actualisation that, is, realising one's full potential, 'becoming everything that one is capable of becoming'. In summary, Maslow (1968) stated that we are all born with a unique set of needs that function in a hierarchical manner. This means lower needs are prepotent and must be satisfied before higher needs



can be activated or fulfilled. The level of self-actualisation is the end-point of a personal growth process and constitutes the highest level of human experience.

The hierarchical nature of Maslow's theory emphasises that psychological needs cannot be satisfied before lower physiological and safety needs such as food and shelter are met. This would fuel the assumption that psychological interventions are potentially ineffective for homeless people who perhaps by definition are not able to meet their basic physiological and safety needs. Neher (1991) presents a detailed critique of the Hierarchy of Needs and concludes that Maslow's model has such theoretical elegance that it has been widely but wrongly accepted and is without empirical support. Acceptance of this theory without question (Soper, Milford & Rosenthal, 1995) may be at least a partial explanation of why clinical psychologists may view being housed as a necessary condition of engaging in a psychological intervention.

### **1.3.2 Empirical evidence for a hierarchy of needs within the homelessness population**

Using the hierarchy of needs as a framework homeless people can be said to experience a deficiency of 'lower order' needs (i.e. physiological and safety needs) that are prepotent for psychological health. Intuitively, it seems likely that homelessness means that basic needs take precedence over higher order needs. However, Sumerlin and Norman (1992) found that homelessness does not necessarily imply an inability to self-actualise. They examined the relationship between basic needs' deficiency and self-actualisation, testing the hypothesis that shelter users and rough sleepers score lower on self-actualisation than a group assumed to have met these lower order needs (i.e. college students). Some homeless men who were involved in a daily battle for shelter, food and clothing over an extended time had equally high self-actualisation scores as the college students.

It is often said that homeless people do not give priority to their health and, in particular, that they are unable or unwilling to get involved in preventative approaches and health promotion activities because basic requirements for food, shelter and money take precedence. Hinton (1997) explored this idea in relation to health promotion and found that homeless people were in fact concerned with their health but experienced homelessness as reducing their own capacity to keep themselves healthy. The voluntary sector, which may be seen as closer to the homeless, was providing health promotion, although most statutory services were not. It may be that homeless people are willing to take responsibility for their health needs, but statutory services are not.

These findings fit with Snow and Anderson's (1987) ethnographic field study of homelessness that observed:

"The salience of identity-related concerns is not necessarily contingent on the prior satisfaction of more physiological survival requisites. Instead, such needs appear to coexist, even at the rudimentary level of human existence" (p.1365).

It seems then that the expectation that 'lower order' needs should be fulfilled before 'higher order' needs can be met is not supported by empirical evidence. This prevailing view could lead to homeless people being excluded from psychology services with no clear rationale.

#### **1.4 Moving on from precontemplation**

As discussed above, the Transtheoretical model indicates how people (or services) *can* change. The role of assertive community treatment and potential roles for clinical psychologists are discussed as a means of promoting change.

#### **1.4.1 Assertive Community Treatment**

In vivo case management approaches such as assertive community treatment (ACT) have shown promise in engaging mentally ill rough sleepers and shelter users in the USA (Johnsen, Samberg, Calsyn, Blasinsky, Landow & Goldman, 1999; Lam & Rosenheck, 1999) and the UK (Kingdon & Jenkins, 1996; The Sainsbury Centre for Mental Health, 1998). Assertive Community Treatment (ACT) programs are characterised by a multidisciplinary team of mental health professionals who provide clinical care and assist clients in meeting their basic living requirements in the client's natural environment. The ACT team, yielding a comprehensive, integrated and continuous provision of services directly provides most of the services needed by clients. Critical elements of a successful service are accessibility, engagement and the capacity to address a wide variety of needs within a model of assertive outreach (Sainsbury Centre for Mental Health, 1998). Randomised trials comparing ACT with usual care (Lehman, Dixon, Hoch, DeForge, Kernan & Frank, 1999; McBride, Calsyn, Morse, Klinkenberg & Allen, 1998) and evaluations of ACT based services (Johnsen et al., 1999) has shown ACT to be a cost-effective management strategy of the homeless mentally ill, especially those with the most severe problems. ACT's may well be successful because their presence promotes an awareness of a mental health need to the individual that may lead them to move on from a precontemplation stage of change.

Whilst the introduction of specialist teams such as those funded by the Homeless Mentally Ill Initiative (Kingdon & Jenkins, 1996), promote an open-access, sensitive service it also maintains the notion that homeless people are a group apart and should be excluded from the rest of society. Whilst improving care in the short-term, they diminish the need for mainstream services to accommodate homeless people who are already a socially excluded group.

### **1.4.2 Role of the clinical psychologist**

The Transtheoretical model of change suggests that perhaps the main task of the clinical psychologist is to assess the level of readiness for change of the individual (or service) and then promote movement across the stages of change until a desired outcome is reached. Kuhlman (1994), suggests that it is beneficial to treat each contact as a single session intervention facilitating the homeless person's readiness to change.

A practical consideration is that clinical psychology is actually a scarce resource within the health service. This shortage, despite efforts to increase the number of training places, has been highlighted as a current concern within the profession (Frankish, 1998) and the NHS (Department of Health, EL (97) 58). This latter document suggested that due to this continued shortage clinical psychologists should disseminate their skills more widely through consultancy, in order to ensure what is described as "the most effective use of resources" (DOH, EL (97) 58).

The need for training, supervision of and consultation to staff who work directly with the mentally ill homeless, an indirect level of intervention, has been highlighted in a number of reports (Anderson, Kemp, & Quilgars, 1993; Craig et al., 1995; Croft-White & Parry-Crooke, 1996; Health Education Authority, 1999; Jones, 1999; NHS Health Advisory Service, 1995; Sheppard, 1996). It may be that there is a role for clinical psychologists to support, educate and consult with outreach workers in how best to encourage a homeless person experiencing mental health problems to engage psychological as well as other mental health services in general. It is likely that the time consuming nature of engaging the homeless person with mental health problems directly will not be seen as an efficient or economic use of such a scarce resource. However, it is possible to see this rationale in a

different light if one contrasts it with the situation in the housed population; it is difficult to see a similar argument being made in that context.

Currently there is little documented evidence of homeless 'users' views at all, let alone about service provision, although one recent study emphasised the need for flexible services (Bhugra, Bharmma & Taylor 1997). The current study attempted to suspend assumptions regarding the role of clinical psychology and invited homeless people themselves to express their own needs, psychological or otherwise.

### **1.5 Summary and rationale for the present study**

Recent research has suggested that mental health problems are over-represented in the homeless population (e.g. Scott, 1993; Gill et al., 1996). Currently mental health services are under-utilised in proportion to need (North, 1994) although equity and access to mental health services within the NHS is a priority (DOH, 1999a,b). There is a limited literature on the role of clinical psychology for homeless people with mental health problems, a group thought to be difficult to engage. This discrepancy between need and service provision may be due to both the individual and services operating within a precontemplation stage of change. This stage of change may be maintained by beliefs about psychological interventions being ineffective unless a person's basic survival needs such as food and shelter are met.

The researcher is interested to know if these ideas are challenged by accounts given by a sample of homeless participants about their homeless experiences including contact with services. These accounts will then be contrasted with the views of clinical psychologists who have provided services for homeless people.

The nature of the research questions and the current lack of literature in this area suggest that a qualitative method would be an effective strategy in order to explore issues from homeless people's and clinical psychologist's points of view. The method of interpretative phenomenological analysis (IPA; Smith, 1995) will be used. Within this approach the researcher has an idea of the area of interest to pursue but at the same time tries to enter, as far as is possible, the psychological and social world of the participant. Through the use of semi-structured interviewing the participant can introduce issues the researcher has not thought of allowing a greater flexibility of coverage and in itself facilitate rapport and empathy. The participant is acknowledged as the expert on the subject being afforded maximum opportunity to tell his or her own story.

Clinical psychologists are in a position to develop services (Ovretveit, Brunning & Huffington, 1992) as well as working indirectly (e.g. training and supervision of others) and directly (Mowbray, 1989) with this population. Exploration of participants' accounts may lead to ideas about vulnerability factors, risk assessment and preventative work as well as informing level and type of psychological intervention. Where clinical psychology, as a limited resource, should be channelled in terms of level of intervention (direct, indirect or service level) and in terms of priority (i.e. many psychology services have long waiting lists of people willing to engage in a traditional 'office' culture) has implications for the clinician's day to day practice.

In conclusion, this research project is timely, it fills a gap in the research literature, has implications for clinical psychology services and practice as well as listening to the views of users themselves. All homeless services that the author contacted were eager that this research was done as many services were hoping to secure funding for clinical psychology. The few clinical psychologists in England working directly with homeless people or homeless services were all keen to take part.

## **1.6 Aim and research questions**

The aim of this study is to find out about homeless people's accounts of their experience of homelessness and engaging with services, in particular mental health and clinical psychology services, and how they see themselves in acquiring and looking for help in relation to mental health needs.

### *Research Questions:*

How do people experience homelessness?

How do homeless people experience services and in particular mental health services?

How do clinical psychologists work with homeless people?

## **Chapter two**

# **METHODOLOGY**



## **2. Methodology**

### **2.1 Pilot Study**

The researcher had intended to conduct a focus group to elicit ideas, thoughts and perceptions about how to engage homeless people who sleep rough or use night shelters. However, the researcher was unable to engage the participants within a group and therefore conducted individual interviews. Lack of interest from potential participants was the reason given for not taking part. Within a user-designed approach, it was intended that the pilot study informed the semi-structured interview schedule used within the main study.

The aims of the pilot were to:

1. Practice engaging homeless people with mental health problems.
2. Assess whether the interview process and structure was acceptable.
3. Interpret from the interviews what to ask in the main study.

#### **2.1.1 Participants**

Three participants were recruited opportunistically from a hostel for people with severe mental illness who had slept rough and/or used night shelters before referral to the hostel. Six people were approached for interview, of these three agreed to take part.

#### **2.1.2 Procedure**

The researcher attended a residents' meeting to explain the study to potential participants two weeks before interviewing. Written information about the study was offered to all the participants (Appendix 1). Participants were asked to give written consent at the beginning of the interview (Appendix 2). All participants were given a copy of the consent form that contained the researcher's contact information. It was intended that another psychologist in

clinical training would observe the focus group. In practice, the observer was present for the individual interviews with the participants' consent. During the semi-structured interview (Appendix 3) the researcher asked additional demographic questions. All participants gave verbal agreement that the researcher could contact them for feedback when the study was completed.

### **2.1.3 Analysis**

Three interviews were analysed using interpretative phenomenological analysis (IPA; Smith, 1996a, 1995). The aim of the method is to explore the participant's view and to adopt, as far as possible, an "insider's perspective" of the topic being studied. At the same time, IPA recognises that this process relies on the interpretative activity of the researcher. The IPA process is described in detail in section 2.2.4 – main study methodology.

A worked transcript is presented in Appendix 4. Examples of the answers given for specific questions are given in Appendix 5. The Pilot Study themes with examples of illustrative text, including at least one quote from each participant that produced the theme, are given in Appendix 6. The observer read the transcripts and the analysis, verifying the validity of the themes. As a result one theme label was modified. A third person checked the reliability of the themes. Inter-rater reliability was calculated using Cohen's Kappa Co-efficient (Siegel & Castellan, 1988) was calculated  $\kappa = .95$ .

Some of the themes were observed to cluster together. Two main themes were produced, interview process and interview structure. Other themes that seemed incidental or unconnected to the pilot aims were dropped. The two main themes provided the basis for

the narrative account presented below that informed the interview process with the homeless participants in the main study.

**2.1.4 Pilot Interview Results**

Table 1 shows the age and some information about the participants' homelessness and psychiatric diagnosis.

**Table 1            Pilot Study Demographic information**

Participant	A	B	C
Age	66	28	43
Time since last slept rough	24 months	Don't Know	13 months
Time spent homeless	20 years	Don't Know	Don't Know
Diagnosis	Schizophrenia	Don't Know	Paranoid Schizophrenia
Other information	Hard of hearing		

Each of the main themes that emerged from the interpretative analysis had a number of sub-themes (Table 2), each of which will be described below. The implications of the two themes on the main study is then described and summarised.

**Table 2            Pilot Main and sub-themes**

Main themes	Sub-themes	Definition of themes	Number of participants for whom themes apply
Interview Process	Motivation to participate	Passivity or lack of control to take part in interview	3
		Wondering whether taking part may result in some gain	2
	References towards interviewer	Curiosity about or references towards interviewer	2
	Impact of mental health	Impact of mental health or medication on ability to take part in the interview	1
	Engagement	Willingness to take part	2
		Sharing personal histories	2
		Disengaged (lack of interest indicated directly or by one word answers)	2
Interview Structure	Preparation	Comments made about interview preparation	2
	Clarity	Clarity of interview questions	1
	Reluctance to speak for others	Inability to put self in "other people's shoes", i.e. speak for others	2
	Present-time focus	Focus on present-time rather than the past or future	1

**Pilot Theme 1:            The Interview process**

All three participants talked about either taking a passive decision to take part in the interview or feeling like they had no choice.

*"Well, you was just coming, that was the end of it. I didn't have to think about it." (A,3).*

*"...before I read the leaflet I was angry. I was angry that they could touch our response and say we're the moby dicks of the system that anybody could come in and say what they want to us. We can, all we can do is just comply or just nod our head or such." (C,6).*

Despite these feelings, Participants A and C spent over an hour discussing whether they would answer the questions the researcher wanted to ask the main study participants. They

made sympathetic reference to the researcher (who is mixed race) indicating they were engaged in the interview process.

*"Well, you're only doing your best ain't yer? Therefore that's the way it is. I'm not trying to pick holes in it, find holes in it" (A, 15).*

*"Not black culture, power of the black, black cult power. I'm not saying that about the likes of you, I'm not trying to make that up" (C, 6).*

Although participants were instructed not to discuss personal material, they shared painful events from the past and said how they had become homeless.

*"Loneliness that you know. Because I'd left my wife and children. I was on medication before I left. I had to leave because I was taking too many medications and they weren't reducing. My wife was giving me a lot of grief and I didn't cause any trouble. Well, I did cause a bit of trouble, but I didn't cause much trouble you know." (C, 10).*

Participant B, seemed disinterested from the beginning of the interview often using one-word answers, yawning and at times his attention wandered.

*"(yawning). Ermmm...yeah, it would be I suppose. But, I don't know, say it again." (B, 4).*

This interview lasted only fifteen minutes, which may have been due to the participant not taking an active decision to participate. During the course of the interviews Participants A and C wondered if they or the main study participants would gain anything tangible from taking part.

*"Well, if there was a possible chance of being able to help me into a flat say." (A, 7).*

In addition to the themes emerging from the interview data the researcher noted that Participants A and C clearly struggled with thought disorder throughout the interview. For

example there would be loosening of associations and losing the thread of the account leading to some difficulty for the researcher to comprehend what was being said.

*"What is good for one isn't always good for everybody is my point. It's just a massive power suit and, suit you? I didn't mean that, but suit of...searching in the suit...it's like the code of one to thirteen, this different models of situations, are they going to suit, we'll take this one and you take that one and that one, and it's all divided up." (C,5).*

Participant C commented on the effect of mental health and medication on being able to function.

*"...there is something wrong with the people, that's what I'm saying, there's something wrong with the people, it's not that they're mad, there's just something wrong with the way they think, that's what I feel" (C,11).*

*"...I didn't feel like the medication allowed me to function" (C,10).*

### **Implications for the interview process in the main study**

From these accounts the researcher interpreted that potential participants might feel pressured to take part by staff, the researcher or the service culture. The issue of choice and conformity might be more pertinent for hostel dwellers whom were likely to be subjected to more 'house rules' than night shelter users or rough sleepers. However, participants' rights to withdraw from the interview at any time would need to be carefully clarified. Lack of interest or motivation to take part was implied by one-word answers and withdrawal from the interview as experienced with Participant B. The fact that he asked to leave suggests that the interview process itself was sufficiently empowering for him to do so. Participants might think that by taking part in the interview the researcher could access

services for them on their behalf. The fact that the researcher could not do this would need to be made clear.

The process of the interview appeared to be acceptable judging by the willingness of two of the participants to share personal stories over a relatively long length of time (that is, over an hour). The researcher was aware that extra support might be needed from staff as potentially painful material might be shared and leave the participant feeling emotionally distressed despite the debriefing that was planned for all homeless participants. In practice this was not found to be necessary in the pilot stage.

Participant's A and C clearly struggled with thought disorder and Participant C put concentration difficulties partly down to a consequence of medication. This might also be the case for main study participants. The researcher was aware that symptoms of mental illness might impact on the quality of the narrative given by participants in the main study. One of the exclusion criteria was that potential participants should not be overtly psychotic because of possible difficulty obtaining informed consent. However, this would not necessarily exclude those exhibiting some degree of psychiatric symptoms.

## **Pilot Theme 2:           The Interview Structure**

Participants B and C mentioned the importance of providing information.

*"Ideas? Well you could say what it was all about, but you did that anyway didn't you?" (B,3).*

Participant C commented on the need to ask clear and relevant questions.

*"It's a straight question. You can say have you ever used a psychology service or seen a psychologist. It is a good question, yeah." (C,14).*

Participants A and B commented on not being able to answer questions on behalf of other homeless people and Participant C commented on sticking to questions about the 'here and now'.

*"Yeah, I can't speak for anyone else though. I can't even think for anybody." (A,9).*

*"I don't know what they'd think." (B,3)*

*"You wouldn't be able to get your head together and answer the question, what was it like when you first left and then come onto now. You can never think of that actually." (C,16).*

### **Implications for the interview structure in the main study**

The importance of accessible information about the study, including the use of posters, and liaison with staff to facilitate recruitment was clear. Meeting participants before interview was likely to help engagement and aid clarification of the purpose of the study. It was clear from the accounts given by the participants that the researcher should stick to asking about their own current narratives as thinking about other people, the past or the future might alienate the participant.

#### **2.1.5 Pilot Interview Summary and conclusions**

The researcher attempted to obtain demographic information during the course of the interview. As the quality of this information was variable, it was decided to include a short demographic questionnaire in the main study. The most pertinent issue to consider for the main study was the issue of motivation for participation in the study, both in terms of consent and outcome of taking part. The accounts given by the participants spontaneously of their past lives indicated that the interview process was acceptable. It was clearly difficult for the participants to answer questions about what other homeless people might think (i.e. putting themselves in other people's shoes). As these kinds of questions are unlikely to be



fruitful, the researcher decided not to ask the main study participants to put themselves in other people's shoes.

#### **Interview schedule questions for the main study**

The pilot interview schedule (Appendix 3) was adapted for the main study (Appendix 7).

The engagement questions one to nine were translated into one question of how participants became homeless that seemed best placed at the beginning of the main study interview schedule. Question ten about service use was kept as it was and became question two. Questions eleven to fifteen about the experience of mental health services was condensed into one general question three. Question sixteen about identifying needs was split into two questions, four and five.

The aims of the pilot study were met and the researcher concluded that homeless people with mental health problems were willing and able to engage in this study.

## **2.2 Main Study – Methods: Homeless Participants**

### **2.2.1 Participants**

Estimates of gender within the homeless population suggest that a much higher proportion of men live in hostels and sleep rough. As a low number of participants would be recruited for this research project, the validity of a gender analysis would be constrained. Therefore male participants were recruited. Participants were excluded from this study if overtly intoxicated or floridly psychotic.

Participants were recruited from a rural Day Centre/Night Shelter and an inner city Day Centre attached to a Night Shelter. Twelve homeless people were approached for interview and of these nine agreed to take part. A further participant (Brian) volunteered for interview having seen the information poster (Appendix 8). During the interview of participant ten, it became clear that he thought he was being interviewed for an assessment of his learning disability, despite the precautions taken to ensure his understanding of the research. However, as the researcher was unclear about the participant's understanding of the consent to this study, the tape-recording of his interview was not transcribed or analysed. Therefore a total of nine participants took part in this study.

Participant five (Edward) was totally blind from birth. It was likely that Edward's visual impairment would have had some influence on both his experiences of homelessness and mental health. However, as this was an exploratory study and Edward fit the criteria he was included. Although the Participant six (Fred) was not assessed to have any psychopathology at the time of interview, he was included in the study as Staff at the Day/Night Shelter reported that they had observed significant signs of mental health problems over since he had arrived there.

Demographic information is presented at the start of the Results section.

### **2.2.2 Measures Used**

To ensure the sample had experienced psychopathology, the use of the General Health Questionnaire (GHQ-12; Goldberg & Williams, 1988) and the Brief Psychiatric Rating Scale (BPRS; Overall & Gorham, 1962) that determines the presence of psychiatric disorder was included in the interview.

#### **GHQ-12**

The GHQ-12 is a twelve-item self-report short-form of the GHQ-60 (Goldberg & Williams, 1988) and is shown in Appendix 9. This widely used measure was designed to detect the presence of psychiatric disorder among respondents in community settings and non-psychiatric clinical settings. It was used to assess the psychopathology of rough sleepers and night shelter users in the OPCS morbidity study of the homeless, where the conservative threshold score of 4 or more to define caseness was used (Gill et al., 1996). For reasons of comparability, the present study will also use this threshold score. This measure was used because of its brevity as well as its reliability and validity. Split half reliability = 0.83, test-retest reliability = 0.73, Specificity = 78.5 percent and Sensitivity = 93.5 percent (Goldberg & Williams, 1988, p.22).

#### **BPRS**

The BPRS is an 18-item widely used (Thornley & Adams, 1998) semi-structured interview shown in Appendix 10. Each of the symptom constructs are scored on a scale from '1' to '7' ('7' being the most severe) adjusted to '0' to '6' to give a common-sense anchor of '0' for 'not present'. A total pathology score is obtained by summing the ratings on all 18 items. Factor analytic studies have supported five higher order factors; thinking disorder,

withdrawal, anxiety/depression, hostility-suspiciousness and activity (Hedlund & Vieweg, 1980). Reliability co-efficient's of .80 or greater are reported for the BPRS total pathology score. Individual items reliability co-efficient's range from 0.63 to 0.83. Higher order factor reliability scores range from 0.86 to 0.94 (Hedlund & Vieweg, 1980). The factor structure of this measure has been tested on a population of homeless people with mental health problems (Burger, Calsyn, Morse, Klinkenberg & Trusty, 1997).

GHQ-12 and BPRS scores will be presented at the beginning of the results section. BPRS raw data and factor scores are shown in Appendix 11.

### **Semi-structured Interview Schedule**

The semi-structured interview schedule was constructed in discussion with two supervisors, one of whom was a clinical psychologist working with the homeless. The pilot study determined the acceptability of the main study questions that appeared to have face validity. The interview schedule is shown in Appendix 7.

The reliability and validity of the conclusions made within this study were tested using a number of criteria discussed by Smith (1996) and Holloway (1997). Transparency of the research process enables replication and comparability to past and future findings. A reflexive diary, shown in Appendix 12 critically examines the researcher's assumptions and actions. The diary enabled the exploration of the interaction between researcher and participants as well as the impact of the research process on the researcher. The presentation of raw material to support the themes, independent audit and inter-rater reliability of the transcripts support the reliability of the present study's conclusions. Coherence of the present study findings with those of earlier work will be examined in the Discussion.

A fuller discussion of reliability and validity in the present research can be found in the Discussion section.

### **2.2.3 Procedure**

All participants were offered study information (Appendix 13). Participants were asked to give written consent at the beginning of the interview (Appendix 14). Daniel did not agree to be tape-recorded therefore brief notes were made during the interview with his consent. A copy of the consent form that included the researcher's contact information was given. Initially, participants were asked a range of demographic questions that included current housing status (Appendix 15). Then, participants were presented with the GHQ-12 (Appendix 9) verbally. Brian completed the GHQ-12 himself. As this measure often prompted narrative about the participants' experiences of homelessness and/or mental illness, each subsequent question was presented when the participant had seemed to finish their account. The researcher then proceeded with the semi-structured interview of open questions (Appendix 7) that attempted to elicit homeless people's accounts of how they became homeless, what services they had used and what help they would like. Questions about alcohol and drug use were asked opportunistically, and all but Daniel mentioned this themselves. The BPRS (Appendix 10) was then presented verbally to seven of the participants. Daniel did not give consent to this part of the interview and due to time constraints in the use of the interview room, the BPRS was not presented to Participant 9. All participants were debriefed after the interview (Appendix 16) and asked for written consent to be contacted again (Appendix 17), all agreed.

### **2.2.4 Analysis**

Nine interviews (eight tape-recorded and one written in note form during the interview) were analysed using IPA (Smith, 1996, 1995). The transcripts were read a number of times, and

anything of significance was noted in the left-hand margin. The next stage identified emerging themes and concepts. The right hand margin was used to note instances of these in the texts. A document was then produced listing the themes and the illustrative text from the nine interviews as described in Section 2.1.3. Examples of two transcripts are in Appendix 18 and 19, those of Arthur and Brian, respectively. These were chosen to show the difference in narrative accounts of someone who showed signs of depression in comparison to signs of psychosis and personality disorder, respectively. A document was produced listing the themes and the illustrative text from all nine interviews. The themes with examples of illustrative text are given in Appendix 20. The transcripts were re-read by a second person (the same as in the pilot study) who verified the validity of the analysis. A third person checked the reliability of the themes. Inter-rater reliability was calculated using Cohen's Kappa Co-efficient (Siegel & Castellan, 1988),  $\kappa = .94$ .

Some of the themes were observed to cluster together, six main themes were produced. Other themes that seemed incidental or unconnected to the main research questions were dropped. For example a seventh theme about mental health that included signs and symptoms of mental illness was dropped, as this information was available from the GHQ-12 and BPRS questionnaires that had been administered. The six main themes provided the basis for the narrative account presented in the results section.

## **2.3 Clinical Psychologist Participants**

### **2.3.1 Participants**

The researcher traced five psychologists in England who had either worked or had attempted to work directly with rough sleepers, shelter and day centre users. Participant One was a Chartered Forensic Psychologist in the process of obtaining a statement of

equivalence to practice as a Clinical Psychologist. Participants Two to Five were Clinical Psychologists. Due to large geographical distance, the interviews were conducted over the telephone, detailed notes were taken and transcribed.

### **2.3.2 The Interview Schedule**

The interview schedule, shown in Appendix 21, was developed in discussion with the research supervisors and was influenced by the literature review and the emerging themes from the analysis of the homeless participants' accounts. In particular the issues of access to services and barriers to engagement were considered to be of most importance.

### **2.3.3 Procedure**

Clinical psychologist participants were asked to complete a questionnaire describing the service in which they worked (Appendix 22). A semi-structured interview of both closed and open questions was conducted over the telephone (Appendix 21) that attempted to elicit accounts of their role in their service, levels (i.e. direct, indirect, service) and type of interventions used and their views on barriers to homeless people's engagement with psychology services. All clinical psychology participants agreed to be contacted later on this year for feedback about the study.

### **2.3.4 Analysis of Clinical Psychologist data**

As the interview schedule for the clinical psychologists was a mixture of closed and open questions and was aimed at answering specific service-related questions rather than interpreting the phenomenology of the clinician's experience, content analysis (Krippendorff, 1980) was used. Manifest content analysis where the instances of particular concepts and categories were counted was used to analyse the closed questions. Inductive content analysis where themes and constructs from the interview data were derived without a prior

framework or frequency count was used to analyse the open questions, similar to the thematic analysis described in Sections 2.1.3 and 2.2.4. A theme of isolation and lack of support emerged from this analysis. A transcript is shown in Appendix 23 and examples of quotes are shown in Appendix 24. A third person checked the reliability of the theme. Inter-rater reliability was calculated using Cohen's Kappa Co-efficient (Siegel & Castellan, 1988) was calculated  $\kappa = .95$ .

## **2.4 Ethical considerations**

This research was designed to follow the British Psychological Society's Code of Conduct, Ethical Principles and Guidelines (1996) and the Division of Clinical Psychology Professional Practice Guidelines (1995). Ethical approval was granted (Appendix 25). Participants made an informed choice about participation, were given written information on the study and how to contact the researcher, and were debriefed after interview. The right to withdraw at any time was made clear. Interview data were kept in a locked box file and tapes were to be erased after transcription. No names were kept on interview data, only numbers. Consent forms were kept separately. Names, places and other potentially identifying details are changed within each transcript.

The researcher discussed any known risk factors with staff before approaching potential participants. Potential participants would not be approached if they displayed overt signs of intoxication due to the use of alcohol or illicit substances. This was not necessary in either the pilot or main study phase of the research. In addition staff would unobtrusively look through a glass window in the interview room door from time to time for the purpose of ensuring the researcher's safety. The researcher had contacted local mental health services at the start of the study and was aware of referral procedures should the



participants become overly distressed during the interview or should the researcher feel that referral was otherwise indicated.

The researcher assessed risk of suicide and self-harm (Edward and Henry, respectively) and risk to her own safety (with Brian) when these potential risks became apparent. Edward had attempted suicide the evening before interview and Henry had self-harmed by cutting significantly in the week before interview. Risk was assessed using the usual clinical procedures of assessing suicidal and self-harm ideation, intention and past behaviour and risk to self was assessed using non-verbal and verbal levels and signs of agitation during the research interview. With permission from Edward and Henry, the researcher gave written feedback about the state of their current mental health and copies of Edward's GHQ-12 and BPRS measures to staff to aid referral to local mental health services. Suicidal ideation was assessed with all participants as they had all spoken and presented with some features of depression.

## **Chapter three**

### **RESULTS**

### **3. Results**

For clarity, analysis of the homeless participants' and clinical psychologist participants' data will be presented separately.

#### **3.1 Homeless Participants**

##### **3.1.1 Demographic and background information**

Age, information about homelessness, mental health status and treatment (current and past) as well as GHQ-12 scores and BPRS total scores are given in Table 3. BPRS raw scores are given in Appendix 11. Where specific questions were not asked, the information is recorded as 'Not Known'. All names given have been made up in order to protect anonymity and confidentiality.

Age ranged from 30 to 57 years. Mean age of the eight participants who gave their exact age was 39 years. Participant 4 reported being in his forties. Table 3 includes brief comments about how the interaction between participant and researcher felt to provide a flavour of what the interview process was like. It is hoped that this context will enable the reader to become familiar with each participant. A more detailed impression of the interview process is given within the reflexive diary (Appendix 12).

##### **Homelessness**

Age at which the participants first became homeless ranged from 15 to 42 years. Six had first become homeless during late adolescence/early adulthood. Time spent homeless ranged from 1 to 30 years, average time spent homeless was approximately 12 years and 5 months. All participants had slept rough, the last time ranged from in the last week (N=4) to

six months ago. Six currently slept in the night shelter, two were in a hostel and one slept on a friend's floor. Two worked, selling the Big Issue, a publication sold at a profit by homeless individuals.

## **Mental Health**

Eight of the nine participants were assessed to have symptoms of depression at the time of the interview. Five had used antidepressants in the past. Two of the nine were thought to have symptoms of psychosis and signs of personality disorder (assessed through presentation at research interview). Only Participant Two (Brian) reported currently taking medication. Five participants had attempted suicide, one the night before the interview, two in the last year and two at sometime in the past. Five participants reported current suicidal ideation and a further participant reported this in the past. Four reported psychiatric in-patient admissions and three reported having had a psychiatric assessment.

GHQ-12 scores ranged from 0 to 12, mean score = 6.77. On this measure six were classified as cases. BPRS total scores (available for 7 participants) ranged from 9 to 29, mean score = 18. On this measure all participants showed signs of some psychiatric symptomatology, most commonly depression.

Participant 6 (Fred) did not display any overt signs of mental health difficulties.

**Table 3      Demographic and background information**

Participant	Arthur	Brian	Charles	Daniel	Edward	Fred	Gary	Henry	Ian
Age	40	42	57	Over 40	35	33	37	30	38
Where sleeping now	Night Shelter	Night Shelter	Night Shelter	Hostel	Night Shelter	Hostel	Night Shelter	Night Shelter	Friend's Floor
When last slept rough	In the last week	In the last week	In the last week	Six months ago	In the last week	Four months ago	Five weeks ago	Six weeks ago	Three months ago
Age when first slept rough	35	42	In 20's	Not known	17/18	15	16	29	18
Years spent homeless	5	1	30	5	3	18	21	9	20
Employment	No	No	No	No	Selling Big Issue	Selling Big Issue	No	No	No
GHQ-12 Score	10	7	12	2	12	0	3	6	9
GHQ -12 Caseness	Yes	Yes	Yes	No	Yes	No	No	Yes	Yes
BPRS Total Score	17	29	16	Not administered	12	14	9	29	Not administered
Current psychiatric signs and symptoms	Depression	Depression, paranoia, personality disorder	Depression, Alcohol abuse	Depression, Suspiciousness	Depression	None	Depression	Depression, OCD, paranoia, self-harm	Depression
Use of medication	Prozac in past	Haloperidol-current Antidepressant in past	Antidepressant in past	None	None	None	None	Antidepressant lustral, mood stabilisers, diazepam, In past	Memoril in past
Suicide attempts	In last year	None reported	Attempt in past	Not Known	Attempt night before interview	None reported	None reported	Attempts in last year and self-harm in last week	Attempts in past
Suicidal Ideation	Current	None	Current	Not Known	Current	None	Current	Current	Past
Contact with psychiatry	Assessment	In-patient	In-patient (had ECT)	Assessment	Assessment	None reported	None reported	In-patient	In-patient
Observations of impact of interview on researcher	Feelings of sadness, hopelessness, expressions of self depreciation dominated.	Watchful, edgy. Feelings of fragility and prickliness throughout.	Feelings of ease and relaxation tinged with sadness	Frustration, Irritation and anxiety	Emotionally withdrawn, but trying to engage.	Fast paced, jovial and humorous.	Seriousness and sadness hidden by wisecracks and flirtatiousness.	Incessant monologue with little interaction.	Feelings of outrage and sadness mixed with hope.

### 3.1.2 Themes

Table 4 shows the main and sub-themes that emerged from the analysis of the homeless participants' accounts. Tables showing the definitions of sub-themes and how many participants mentioned that theme will be given in sections for each theme. Examples of quotes for each sub-theme will be given and discussed.

**Table 4        Main and sub-themes**

	Main Theme	Sub-themes
1.	Experience of homelessness	Causes of homelessness
		Homelessness as violent and frightening
		Homelessness as stressful and frustrating
		Homelessness as safe and protective
		Homelessness as excluding
2.	Experience of services	Caring and supportive
		Inaccessibility
		Excluding and rejecting
		Incompetent
		Inappropriate or unacceptable
		Abusive
3.	Sense of self	Low self esteem
		Independent and able
4.	Loss and trauma	Loss
		Childhood abuse
		Childhood separation
5.	Coping	Coping by withdrawing physically or emotionally
		Coping by using alcohol or illicit drugs
		Coping by acting aggressively towards self or others
		Coping by being homeless
		Coping by having relationships
6.	Identified Needs	Basic needs
		Relationships/counselling
		Work/ things to do
		Service provision

### 3.1.3 Table 5 Theme 1: Experience of homelessness – sub-themes

Sub-theme	Definition	Number of people who mentioned it
Causes of homelessness	How people became homeless.	9
Violent and frightening	Homelessness as a violent and frightening experience	9
Stressful	Homelessness as a stressful experience	4
Safe and protective	Homelessness as belonging to a safe group	4
Excluding	Homelessness as excluding and rejecting	4

#### Causes of homelessness

Everyone said in some detail how he had initially become homeless. For five people this was at least partially due to a breakdown in their relationship with parents or stepparents. The age range of these people when first homeless was 15 to 21. Two people said that a breakdown in an adult relationship with a partner led to homelessness. Two people described becoming homeless initially as a consequence of mental health difficulties and one person said that alcohol abuse was the cause.

#### Homelessness as a result of a breakdown in parental relationship

*"...my mother threw me out of the house and I was left to fend for myself" (Edward, 7<sup>1</sup>).*

*"Mum and Dad were getting divorced. They were going through a bad patch. I thought get out while the going was tough." (Ian, 2).*

#### Homeless as a result of a breakdown in adult relationship

*"I broke up with my girlfriend...I moved out a few miles away... thought I was coping well.. One day I just got up and instead of going to work, I just took my last ten pounds out the bank and put some stuff in a ruck sack and walked to the lakes." (Arthur, 4)*

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<sup>1</sup> Numbers after name refer to page number in transcript. All names are false.

## **Homelessness as a consequence of mental health difficulties or alcohol abuse**

*"Wanted to rest mentally. Unable to do that in this country so went abroad for five years (six years ago)." (Daniel,2).*

*"I'm homeless through drinking. That's why I'm homeless." (Charles,3).*

## **Causes of subsequent homelessness**

Some people had lived in both temporary and 'permanent' accommodation on and off since they were first homeless. This included council flats, hostels (both voluntary and statutory) and privately rented accommodation. There were multiple reasons given for becoming homeless after the first time. These included loss of work, alcohol abuse, service failure, relationship breakdown, as a result of being assaulted, and eviction.

*"I know how I've become to be homeless, I know exactly how I've become homeless, because I had a job and I lost it and I lost my flat and I'm homeless, simple really, simple thing." (Gary,11).*

*"Well I was really depressed I don't think it was other things...I mean I had a good job and I regret losing it really... you know my dad was right I've wasted my life through drink." (Charles,4).*

*"I: And then you've been homeless consequently, how did that happen?*

*P: ...violence towards me..." (Edward,7),*

*"I think it was down right cruel to me, certainly when people were fully aware of me problems and knew I was a vulnerable person to be sleeping rough on the streets basically and shouldn't even be out on the streets, I think it was all wrong. And it couldn't have been a worse time for someone to be evicted as well." (Henry,40).*



## **Homelessness as a violent and frightening experience**

Everyone had either witnessed violence or death, or had felt unsafe and/or had been assaulted or robbed whilst homeless.

*"I arrived here on Thursday...I'm standing on the kerb having a cigarette, I just see poor old Lee getting filled in by three blokes." (Henry,49).*

*"This lass tried to commit suicide for about the tenth time, she was living in a squat...she had taken all the pills, so it's her own fault really. This time, this time I said I'm going to sit and watch her die and that freaked her out a bit, so I phoned an ambulance." (Fred,11).*

*"I've actually been in L [Town]<sup>2</sup> for what 20 years and I've seen people die on the street, young kids taking overdoses." (Gary,7).*

## **Homelessness as stressful and frustrating**

Homelessness was experienced as stressful and frustrating.

*"Even though all the support was here [day/night shelter] I just ...it can be quite a stressful place to live at times. Very stressful actually. For anybody. No matter what state of mind they're in." (Arthur,20).*

*"A homeless person is under stress..." (Brian,19).*

## **Homelessness as safe and protective**

In contrast, at other times some people found homelessness gave them a sense or opportunity to belong to a group that could be experienced as safe and protective.

*"...we are people no matter what race, colour, whatever we are, we are one person." (Gary,11).*

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<sup>2</sup> Classificatory information in square brackets added by the author

*"I've got a lot of friends down here [day/night shelter]..." (Ian, 6).*

### Homelessness as a means to be excluded

Some felt stigmatised or excluded because of their homelessness.

*"A lot of people think you're scum and we're not scum we're ordinary people." (Gary, 11).*

*"They deliberately don't tell people about it [UC, voluntary sector day centre] 'cos the UC doesn't want people from the homeless centre going to their mental health centre."  
(Brian, 19).*

#### 3.1.4 Table 6 Theme 2: Experience of Services – sub-themes

Sub-theme	Definition	Number of people who mentioned it
Caring and supportive	Supportive, caring, helpful	7
Inaccessibility	Lack of information, barriers to getting a service	6
Excluding/rejecting	Services don't want to know, listen or care	6
Inappropriate/ Unacceptable	Services not wanted or 'right'	6
Abusive	Harmful or unhelpful services	4
Incompetent	Services don't know what they're doing	3

### Services as supportive, caring and helpful

Many of the participants had experienced supportive, helpful relationships with individual service providers.

*"You don't have to come in here for a counselling session. She just sits next to you and sees if you want to talk...And that's what I think what people need." (Arthur, 7).*

*"...staff have always looked after you..." (Ian, 27).*

## **Inaccessibility of services**

In contrast, at other times services were experienced mostly negatively. Services were experienced as hard to access because of lack of knowledge about them, long waiting lists, not open for long enough or being too bureaucratic.

*"...the information that everyone can seek and access is not available for me to find out about." (Edward, 11)<sup>3</sup>.*

*"I haven't started yet as I say there's a very long waiting list. Three or four months." (Arthur, 10).*

*"The least helpful thing is the fact that it's a Saturday, on a Saturday none of the day centres are open, none of the night shelters, basically on a Saturday if you're homeless, then you go homeless, no where to go..." (Edward, 12).*

*"...all the rules have all changed, you've got to be referred by certain people, certain places whatever, but years ago, when I used it there was no on line sort of like website thing, there was nothing like that. You had your book in front of you, you phoned up the agencies and they had somewhere then great excellent you had a place, simple as that." (Gary, 13).*

## **Excluding and rejecting services**

Some felt that services did not want them or did not listen or understand what they wanted.

*"Originally I couldn't get into a doctors surgery because nobody wanted me." (Arthur, 9).*

*"When I tried to get a doctor...I showed them these [letters from hospital] and they didn't want to take me as a patient I think because they didn't want to get into a complicated... and*

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<sup>3</sup> Participant is blind.

*they said we don't want him as a patient, maybe its because of the alcohol, I don't know."*

*(Charles, 9)*

*"U (Voluntary Sector Mental Health Day Centre). It's too clinical, too small, can't drink or smoke there so homeless people won't use." (Daniel, 3).*

## **Inappropriate or unacceptable services**

Some services were just not what was wanted.

*"I think to be able to find me a room or a bedsit or a flat even...this place is driving me nuts... The noise, it's quiet today but sometimes its terrible...it's too noisy." (Charles, 20).*

*"I've tried them, I've tried the ARP [detox], to me that was a waste of time." (Gary, 8).*

*"...the job centre's pushing you into jobs where you don't want to go into that job." (Ian, 11).*

## **Abusive services**

Service provision was experienced as unhelpful or unsupportive, sometimes even harmful and creating dependency.

*"Apparently I was fit enough to stagger down the road to Social Services office and again organise things for myself." (Brian, 11).*

*"I had this ECG treatment directed through me, shock treatment you know...personally I think its harmed me because ever since then I've had a bad memory..." (Charles, 4).*

*"I think I've become emotionally dependent on them really at times. Which is not a really good thing really." (Arthur, 14).*

**Incompetent services**

Sometimes, services seemed incompetent or useless.

*"Unfortunately [local council] decided to have an incompetent computer department that messed up by housing benefit application." (Brian,12).*

*"I mean, the Homeless Departments, they're completely useless." (Fred,9).*

**3.1.5 Table 7 Theme 3: Sense of Self – sub-themes**

Sub-theme	Definition	Number of people who mentioned it
Low self esteem	Low opinion of self, or self as difficult and/or vulnerable and/or can't do things	5
Independent and able	Sees self as independent and able	5

**Low self-esteem**

Over half clearly expressed negative views of themselves, although this theme was experienced as pervasive to all by the researcher within the interviews. Not only did they not think much of themselves, they did not think other people thought much of them or were interested either.

*"I don't have very much self-esteem. Or, you know, no self-worth or anything." (Arthur,13).*

*"They just did not think did I need the support, they didn't think that I was worth being bothered about, they didn't think I was that important..." (Henry,24).*

**Independent and able**

There was some sense of competency and independence expressed by people able to get things done and feeling good about themselves.

*"I'm so good at it, they kept on asking me to do things instead of doing things themselves..."*  
(Brian, 5).

*"I like to sort things out myself." (Fred, 14).*

*"I did a whole play, I've actually done something, and I'm really proud of it, I actually got to do something that I thought was worthwhile doing." (Gary, 12).*

### 3.1.6 Table 8 Theme 4: Loss and trauma – sub-themes

Sub-theme	Definition	Number of people who mentioned it
Loss	Loss of relationships	8
Childhood abuse	Physical or emotional abuse as a child	2
Childhood separation	Separation from parents as a child	2

#### Loss

As well as the obvious loss of a 'home', most people experienced the loss (or potential loss) of close relationships with parents, partner or children.

*"...the reason I'm homeless this time is I could have kicked my girlfriend out the house with my son, but kicking my kid out of his home, I'm not going to do that am I. He's better off with his mother, but sadly I left him so I can't look after him." (Fred, 13).*

*"I have lost friends. You know who disapproved of drinking. And my family, I hadn't had any contact with them for six or seven years. Through drinking, because they disapprove of it."*  
(Charles, 3).

## **Childhood abuse**

Two people reported emotional and/or physical abuse as a child.

*"When I was about 6 or 7 I can distinctly remember something that he probably doesn't even remember. A few times he'd come home very drunk, but because he could handle it he'd ended up taking the mickey out of me, and I was like seven years old. Not letting me go to my room, not letting me, I was one of those kids who ended up shutting himself in the wardrobe because he didn't want to hear mum and dad shouting at each other all the time. There was no physical abuse at all. But what my father doesn't realise is that he psychologically abused me something rotten." (Brian, 8).*

*"...there was a time where my mum got that violent with me she ended up putting a kitchen knife to my throat one night and threatened to slit my throat..." (Henry, 10).*

## **Childhood separation**

Two people had been placed away from home as a child.

*"I was brought up in children's homes...until the age of 12 from 6, six years, I was at boarding schools, as they were called, but they weren't boarding schools it was approved schools, so that's it...I was stuck away without my parents..." (Gary, 6).*

*"I was about six when this happened...my dad said I'm sorry son I have to put you into care because I can't cope." (Henry, 11).*

### 3.1.7 Table 9 Theme 5: Coping- sub-themes

Sub-theme	Definition	Number of people who mentioned it
By withdrawing physically or emotionally	Coping by leaving the situation or withdrawing emotionally	6
By using alcohol or illicit drugs	Coping by using alcohol and/or illicit drugs	5
By acting aggressively towards self or others	Coping by acting out aggressively	4
By being homeless	Coping by being homeless	2
By having relationships	Coping by initiating or maintaining relationships	2

Life situations were coped with using a range of strategies that usually meant that the person did not fully experience the stressor if at all. For example, leaving the situation physically or withdrawing emotionally, being homeless and moving on, or using alcohol or drugs. One person acted out aggressively as a means of drawing attention to himself and seeking help.

#### Coping by withdrawing physically or emotionally

*"I kind of just cut meself off from people. Don't trust anybody." (Arthur,7).*

*"I don't worry about it. If people spend too much time worrying then that's why they don't get nothing done. I've got a thick skin, you know, I just get back up, brush myself down and get on with it." (Fred,7),*

#### Coping by using alcohol or drugs

*"I was obviously depressed anyway...I got to smoking marijuana and drinking too much beer..." (Arthur,7).*



*"I usually find that when I'm smoking Cannabis is when I really feel, it's not that I'm dependent on Cannabis its just that I tend to find that everyone else around me, they tend to be different and it brings me into a better frame of mind." (Edward,23).*

### **Coping by acting out aggressively**

*"I wasn't getting anywhere and I wasn't being successful with anything I ended up slowly giving up, ended up going out time and time again and getting pissed up, going out in the middle of the town, or at home, causing such a scene, not just to attract the attention, and attention seeking but to try and make people realise how much I'm really hurting inside and how much pain I'm in and how much grief I've had." (Henry,25).*

### **Coping by being homeless**

*"I spent three months living rough there...I've been moving on ever since. Just running away from my problems." (Arthur,4).*

*"Worked hard. Wanted to rest mentally. Unable to do that in this country so went abroad for five years (six years ago). If want to rest mentally, what are the options? Go into the mental health system. Be homelessness." (Daniel,2).*

### **Coping by having relationships**

Two people described having a relationship as a way to cope with homelessness or mental health problems.

*"If it wasn't for K last night I would probably have walked away and done it [completed suicide attempt ] anyway." (Edward,15).*

### 3.1.8 Table 10 Theme 6: Identified Needs – sub-themes

Sub-theme	Definition	Number of people who mentioned it
Basic needs	Food, safety, protection	7
Relationships/counselling	Belonging, trust	6
Work or doing things	Something to do, feel good about self	4
Service provision	What services need to do	2

Everyone was able to identify what their needs were and some gave an indication of how they would like services to provide this.

#### Basic Needs

*"A secure place to live, shared or not shared, preferably not shared because I'm 42 now and I don't really want to share..." (Brian, 15).*

*"...somewhere to live would be nice, properly, not a hostel which is going to kick you out tomorrow or renew you after 28 days, and it is renewable..." (Gary, 14).*

#### Relationships/counselling

*"Something that could just give me the confidence and the ability to lead a normal life. I hope counselling could do it." (Arthur, 12).*

*"I wanted help basically. Support, to help me get through these traumas, get my head and my life together again, get my confidence back, self esteem and ability back...get into another relationship with another nice lady..." (Henry, 24).*

#### Work or things to do

*"Basic things, yeah, to wanting to lead a normal life. To get a home, get a job, settle down, start a relationship." (Arthur, 12).*

*"Make it possible for me to have a job and is useful. Not just pushing bits of paper about."*  
(Brian,17).

*"...people have helped me, in hospital, in here and I go to the soup kitchen sometimes and I mean they help, and I think I should be helping people, shouldn't I."* (Charles,26).

## **Service provision**

*"Need simple, direct services where you see one person who helps you to plan what you need to do to get where you want."* (Daniel,3).

*"The service should be available 24 hours"* (Edward,29).

## **3.2. Clinical Psychologist Participants**

### **3.2.1 Background Information**

Background information about the clinical psychologists' place of work is given in Table 11.

Four work in teams or provide a service specifically to the homeless. Participant Four provided consultation only to a large voluntary sector organisation for the homeless under-25 years. Two worked more or less full time, one part time and two a nominal amount of time. Two services were at least partially funded by the Homeless Mentally Ill Initiative (HMI). Number of current and annual clients was recorded for the team. For Participant One, this was the number of current and annual contacts. Three worked within multidisciplinary teams. Inclusion and exclusion criteria for clients varied.

**Table 11 Clinical Psychologist background information**

Participant number	One <sup>4</sup> CP1	Two CP2	Three CP3	Four CP4	Five CP5
Type of service	Independent Worker with homeless	Homeless CMHT	Homeless CMHT	Consultation only	Homeless Primary Care Team
Average sessions/week	10 plus	4	9	0.5	0.5
Funded by	HMII	NHS/Social services	HMII, NHS, Social services	NHS	NHS
Outreach service (Yes or No).	Yes	Yes To hostels/ night shelters & day services.	Yes	Not applicable.	Yes
No. of current clients	60	48	85	Not applicable	50
No. of clients over a year.	720	300-350.	185	Not applicable	2000
No. of workers w.t.e.	1	10.9	21	Not applicable	3
Profession of workers	Psychology	Nurses Social workers Resettlement workers Psychiatry	CPN's, Social services, GP, Psychiatry alcohol nurse, resettlement and support workers	Not applicable	CPN, Nurse, Medical advice
Inclusion criteria	Anyone referred from homeless services	Severe Mental Illness	Roofless or no tenancy	Not applicable	Anyone homeless in broad sense of the word
Exclusion criteria (if not just the opposite of inclusion criteria)	None	Primary diagnosis of alcohol or drug abuse, personality disorder			Those with a GP.

<sup>4</sup> Participant One was a Chartered Forensic Psychologist in the process of becoming a Clinical Psychologist.

**3.2.2 Content Analysis of Clinical Psychologist interviews**

**Table 12 Referral to clinical psychology**

<u>Main Referral Routes</u>	<u>N of CP's giving route</u>
Hostel workers	3
Outreach & Resettlement Teams	3
Nurses (CPN or General)	3
Drop in/Open Access	2
Statutory services (e.g. Police, A&E)	1

The main route into psychology was via referrals from within the team or to the main team from workers in the homeless field. Typically these were hostel or day centre workers. Direct referrals were made to Participant One who did not belong to a Team. Participant Four provided ongoing consultation only to a large Voluntary Sector organisation to the homeless.

**Table 13 Presenting Problems**

<u>Main Presenting Problems</u>	<u>N of CP's who mentioned problem</u>
Childhood Abuse	5
Emotional intolerance/anger management	4
Self-harm or suicide attempts	3
Psychosis	2
Depression	2

The most common presenting problems referred to the psychologists were histories of childhood abuse, experience of trauma and difficulties in interpersonal relationships. Interpersonal difficulties included issues around emotional intolerance and requests for anger management.

**Table 14 Role of the clinical psychologist**

<u>Level of Intervention</u>	<u>N of CP's who mentioned level of intervention</u>
Consultancy	5
Supervision	3
Direct work	3
Training	2
Service development	1
<u>Psychological models used</u>	<u>N of CP's who mentioned model</u>
Solution Focused Therapy	3
Psychodynamic principles (indirect)	3
Cognitive-behavioural	2
Motivational Interviewing	2
Systemic	1

All the psychologists provided consultancy mainly to staff in hostels. Supervision to a range of trained (e.g. Community Psychiatric Nurses) and untrained staff was provided by three. Three psychologists engaged in direct work with homeless individuals. One psychologist was involved in the training of staff in hostels and one psychologist was involved in 'in-house' service development.

Solution focused and cognitive behavioural interventions were most commonly used within the direct client work. Three psychologists used a psychodynamic perspective to think about transference and counter transference issues in their own interactions with clients as well as the interaction between the individual and the organisation as a whole. Participant Four who provided consultancy only, also used systemic approaches in his work.

**Table 15 Engagement strategies and barriers to engagement**

	<u>Engagement Strategies and barriers</u>	<u>N of CP's who mentioned the strategy or barrier</u>
<u>Engagement Strategies</u>	Through worker known to client	4
	Flexibility/informality	4
	Outreach	4
	No 'did not attend' (DNA) policy	3
<u>Barriers</u>	Appointment systems as a barrier	4
	Negative past experiences of services	2
	Length of time homeless as a barrier	1
	History of abuse	1
	Ambivalence or lack of 'psychological mindedness'	1

Engagement with clients tended to happen through service providers already known to the client. Outreach in terms of flexibility around where and how the service was provided was highlighted as important. All psychologists mentioned barriers to engagement due to service practices. Appointment systems and negative attitudes of service providers was mentioned in particular. One psychologist said that the length of time a person was homeless and a history of abuse led to individuals not engaging with services. The notion of a lack of 'psychological mindedness' was mentioned as a potential barrier to engagement.

**Table 16 Wanted and planned service developments**

<u>Wanted and planned service developments</u>	<u>N of CP's who mentioned the development</u>
Increased psychology time	4
No change planned	4
Training of non-psychology workers	1
Recruitment of clinical psychologist	1

Four of the five mentioned an increase in psychology time or numbers of staff in order to develop the service further. Four thought that there would be no service developments and possibly less or no psychology time given to the homeless in the future. One mentioned that the service was trying to recruit another psychologist.

### 3.2.3 Theme of isolation and lack of Support

One theme emerged from the accounts given by the clinical psychologists which was a feeling of isolation, lack of support and hopelessness that this would change.

*"One person providing everything, extremely tiring...Post needs to be rotating, otherwise would burn out. Even with support, should be a time limited role." (CP1,8).*

*"I feel useless; I am not giving them a service at all. I know the nurses and staff find it valuable. The whole service needs to be developed but there's no time, I don't feel I'm doing what I should be doing." (CP5,4).*

*"Being stuck, not knowing what to do. I don't get any supervision for this work." (CP5,4).*



## **Chapter four**

### **DISCUSSION**

## **4. Discussion**

### **4.1 Discussion of findings in the light of previous research**

#### **4.1.1 Pilot study**

The theme of not wanting to speak for other people was, in hindsight not so surprising, as the heterogeneity of the homeless had already been noted (Brandon, 1998). It may be that these men did not identify with other homeless people because the homeless, especially with mental health problems are typically viewed in a negative way (Bhugra, 1998). These men may have protected their own self-esteem by not identifying with this negative stereotype. This explanation fits with Tajfel's (1981) account of self-esteem and social categories. He suggests that people are motivated to see themselves as different from, and better than other groups in order to enhance self-esteem. The desire for social distance from negatively valued groups has typically been studied in relation to people with mental health problems, but it is also likely to apply to homeless people with or without mental health problems.

#### **4.1.2 Main study homeless participants**

##### **Experience of Homelessness**

The most common reason for initial homelessness within the present study sample was relationship breakdown with parents or significant others. This was comparable to the findings in the Rough Sleepers Report (Social Exclusion Unit, 1998) and statistics available from the Department of the Environment, Transport and the Regions (DETR; 2000). A history of broken relationships and abuse supports Sumerlin's (1999) findings that

homelessness is likely to be perpetuated in adult life. For Brian and Daniel, initial homelessness was due to mental health difficulties and for Charles cause of initial homelessness was related to alcohol abuse, although he had also been admitted to hospital for depression and had separated from his wife at the same time. The reasons for homelessness in this sample were therefore typical of people who sleep rough.

The high degree of exposure to violence supports findings by Fitzpatrick et al. (1999) and the experience of homelessness as stressful compares to findings by Meltzer (1995). Experiences of exclusion were typical of those described by Sayce (1998).

### **Experiences of services**

At a service level most of the men reported experiences of positive, caring and helpful service provision mainly from individual service providers. There were many more instances of negative past experiences of services dominating their accounts. Services were seen as inaccessible either because of a lack of information about them or service provision not being available twenty-four hours a day seven days a week. More than that, services were seen as excluding and rejecting. Further when the men had accessed a service they experienced incompetence, found them inappropriate to their needs or wishes and sometimes even abusive. The Clinical Psychologists who had taken part in this study supported this account of services as inaccessible for all these reasons. Negative past experiences and rigid appointment systems were seen as a barrier to homeless people engaging mental health services. This account of service provision reflects the barriers to engaging services discussed in the introduction (for example, NHS: Advisory Service, 1995).

This study supports the view that both ignorance of services and a poor reception when the person has got there are likely to lead to demoralisation that maintains the homeless person with mental health problems in a position of precontemplation in relation to seeking help for mental health needs.

### **Sense of self and coping strategies**

To become ready to change, or seek help, the men would have to have expected that change could occur, and this theme did not emerge from the data. Many of the men reported symptoms of depression and low self-esteem. The predominant coping strategy of withdrawing physically and/or emotionally, often with the aid of alcohol and/or illicit drugs meant that these men were unlikely to seek help. Only one person was currently prescribed medication, despite the evidence of significant depression for the majority of the sample. Some people stated that homelessness was stressful and like Bentley's (1997) sample of homeless people, may have felt too vulnerable to talk about their mental health needs. However, this would seem negated by the fact that they did engage with the researcher and did talk about painful issues.

### **Identified Needs**

The homeless men were clearly able to identify a number of needs that can be seen to fit along the whole spectrum of Maslow's Hierarchy of Needs (1968). Although most of the men mentioned basic needs such as food and shelter, they also wanted to build significant relationships and have things to do. Arthur, Brian and Ian specifically mentioned the need for counselling or 'stress therapy'. These identified needs could be thought of as corresponding to a wish to fulfil the higher order love and belongingness and self-esteem needs. Gary had recently taken part in a play and spoke about how proud and worthwhile

he felt through doing this, possibly equating to a self-actualisation experience similar to those found by Sumerlin & Norman (1992).

Brian, Fred, Gary and Ian mentioned belonging to a group or having friends that contributed to a feeling of safety. The positive comments about the experience of services tended to be about helpful relationships with service providers, suggesting that homelessness does not preclude the ability to fulfil higher order needs. These findings fit those reported earlier from Hinton (1997) and Snow and Anderson (1987).

In conclusion the homeless men were able to identify and in some instances fulfil higher order love and belonging and esteem needs. Many of the participants identified wanting relationships, or counselling or simply wanted to talk. This is particularly remarkable given the prevalence of psychiatric morbidity and in particular depressive symptomatology, pervasive low self-esteem and a generally negative experience of services.

### **Tentative Synthesis of themes**

The accounts of the nine participants had a lot of common elements that the researcher attempted to pull together to form a tentative narrative account of the group. Early losses or abuses may leave people vulnerable to difficulty dealing with a crisis in adult life (for example, relationship breakdown or other life events). It may be for this particular group of people their specific type of vulnerability involves escape behaviour – either escaping to the streets (a direct route to homelessness) or through taking to alcohol, or in other cases mental health breakdown ensues. Within the context of less than ideal service provision or treatment for mental health difficulties (perhaps exacerbated by suspiciousness on the part of the individual) this in turn leads to another route to homelessness. From homelessness, people then enter a deprivation cycle, where getting back into mainstream society is difficult

because of prejudicial attitudes and exclusion, and inaccessibility of services – and again perhaps also suspiciousness and hopelessness on the part of the individuals' involved. Developing a sense of independence from having to live on their 'own wits', as well as coping by withdrawal and alcohol or illicit drug use, maintains the state of homelessness.

One possible route out of this cycle is through more accessible services and on-going support leading to re-entry into the homed world. However, it is likely that these individuals would still be vulnerable to crises in relation to homelessness and mental health, because they may have sustained psychological damage that is deep-rooted, either early on in life or subsequently.

#### **4.1.3 Clinical Psychologist Participants**

Homeless people were able to self-refer to two clinical psychologists through drop-in/open access sessions or informally approaching them typically within day centres. Referrals mainly came through the team in which the psychologist worked or had links with, suggesting that the teams provided an additional gate-keeping role to psychology.

Most of the psychologists' sometimes extremely limited time, was employed indirectly using a range of interventions, consultancy and supervision of other professionals and workers in the homelessness field. The most common presenting problems were around childhood abuse, emotional intolerance/anger management and self-harm/suicide attempts. This seemed to fit with the high levels of abuse, exposure to violence and severe psychopathology within the homeless population mentioned in the literature review (section 1.1.4), and found in this study's sample of homeless men.

Solution focused interventions were used most often in direct work. Participant One mentioned using this model as a means to engender hope in what would often be one-off time-limited sessions. The clinical psychologists worked hard to engage and keep clients engaged mainly by using flexible, assertive approaches similar to those outlined in the document *Keys to Engagement* (Sainsbury Centre for Mental Health, 1998). Flexibility and assertive outreach were inter-related and typically meant trying to avoid giving appointment times, being informal with the (potential) client, for example having a cup of tea and a chat. This was also enhanced by not having a discharge policy as such. If clients did not turn up when expected, then the psychologist would actively look for them in their usual places and they would not be discharged.

Apart from the psychologist who provided consultation only, all the psychologists wanted to increase psychology time with the homeless suggesting that they thought there was a gap between psychological need and service provision. Comments made within the theme of isolation and lack of support indicated that the clinical psychologists did not feel they were providing the most efficacious service they could because of lack of time and resources. A second motivation for increasing psychology time was revealed within the theme of feeling isolated and unsupported within the organisation in which they worked. It is likely that the individual clinicians were also in a position of feeling demoralised by lack of resources that impacts on the ability of a service to make effective changes (Bandura, 1993; Prussia & Kinicki, 1996). This may have had an impact on their decision to spend most time engaging in indirect levels of intervention, perhaps maintaining the perception that homeless people are not able to engage in one to one therapies.

#### **4.1.4 Summary and conclusion**

This study shows that this sample of homeless men with mental health problems identified a range of needs, some of which they were able to fulfil. Despite this, a high prevalence of mental distress, mainly depression, remained untreated, a situation that supports the findings of North (1994) and Bhugra (1998).

Using the Transtheoretical Model of Change (Prochaska & Prochaska, 1999) and relating the lack of help seeking behaviour or service provision for this group to a notion of not being ready to change provided a useful framework for bringing together the complex, dynamic factors that help or hinder a homeless person with mental health problems receiving a psychology service.

### **4.2 Critique of methodology**

#### **4.2.1 Sample**

The pilot study highlighted some issues about research with homeless people with mental health problems. Motivation to take part may be lacking or not for the altruistic reason of helping others further psychological knowledge. Two of the pilot participants clearly showed signs of thought disorder. The researcher's professional background and therapeutic skills enabled rapport to be facilitated and their participation was invaluable in devising the main study interview schedule.

This study could be criticised for the small sample size, which may not have been typical in composition, in relation to the users of night shelters/hostels and rough sleepers. The prevalence of psychiatric caseness in this sample measured with the GHQ-12 (Goldberg & Williams, 1988) was comparable to the night shelter and day centre users in the OPCS



study of psychiatric morbidity (Gill et al., 1996). The homeless participants were recruited opportunistically usually after a period of informal contact with the researcher within the setting of the day centre. A high proportion of those approached for interview agreed to take part. Participation may have reflected individuals wanting something to do. Alternatively, taking part in an interview about what the individual would like and how psychology might be able to provide this might have been perceived as validating and empowering.

The clinical psychology sample was also very small. However, the clinical psychologists were recruited through word of mouth and are the only five psychologists working specifically with the homeless population as far as the researcher was aware (100 per cent response rate). Therefore accounts of how clinical psychologists work with this population would appear to be representative.

#### **4.2.2 Procedure**

##### **Power issues**

Considering the position of homeless people, it is necessary to consider whether there may have been an issue of interviewer influence in terms of unequal power, especially since the interviewer began by administering the GHQ-12. The participants may have perceived the beginning of the interview as akin to a clinical interview rather than an exploration of their worldview because of this. However, the GHQ-12, in addition to detecting 'psychiatric caseness' as a description of the participants current mental health status, also prompted discussion of homeless people's lives. It is likely that even without the administration of the GHQ-12 participants would have talked about their own mental health in the same way that the pilot participants did, the latter having been expressly asked not to. In practice, many participants expanded their answers to the closed questions and the researcher prompted

them to follow through before resuming the presentation of closed questions. In this way the participant was able to lead the interview.

The semi-structured interview of just five questions was enough to prompt interviews that averaged 90 minutes (and in one case four hours) of relevant data. Having engaged in the interview most of the participants then consented to the presentation of the BPRS. Using standardised measures in this way seemed to be acceptable to participants and confirmed the presence of psychiatric symptomatology in the majority of the sample.

Some comments were interpreted to be indirect references towards the researcher. These were mainly about service providers not understanding the position of the homeless person because they had not been homeless themselves. However, the fact that they made such statements could be taken to indicate that they did not feel constrained to give 'desirable' or expected responses.

The researcher thought that her status as a psychologist in clinical training allowed the clinical psychologist participants to be frank and open about their work. The themes of isolation and lack of support may not have arisen otherwise. The researcher was able to facilitate the beginnings of a potentially supportive network for psychologists working with homeless people by sharing contact details of each other with the participants' permission.

### **Interpreting the data**

In line with the interpretative phenomenological approach, how the researcher's ideas and assumptions may have influenced the research process was detailed in the reflexive diary (Appendix 12). For example, the researcher had expected that participants would discuss a

range of needs and this may have affected her interpretation of what needs were identified by the homeless people.

The researcher did not attempt member validation (Smith, Osborn & Jarman, 1999) as a means to check the interpretations she had made. Member validation has both methodological advantages and disadvantages. Checking if interpretations seem to fit with the individual and giving information back to participants could have led to a fuller account of the homelessness experience. However, the researcher attempted to go beyond the individual experience and reported *shared* themes. Individual participants may not have recognised their accounts within the group narrative or want to change or ad lib to their script creating another cycle in the research process that was beyond the time limitation of this study. The appended reflexive diary (Appendix 12) and transcripts (Appendix 4, 18, 19 & 23) are available to the reader to check the process of theme generation (that is, an audit trail).

The main theme of 'experiences of services' was not broken down into the type of service the participant was talking about. The researcher did not seek clarification on all accounts of service provision as this was thought to interrupt the flow of the participants account, reflecting the preoccupations of the researcher rather than the participant. The researcher assumes that it is likely that negative experiences of past services would influence future experiences of services and would impact on engagement with clinical psychology.

The interview process itself was a chance for participants to be listened to. Judging by the length of the interviews, this was perhaps a valuable experience in itself. This is valuable information given this population are typically seen as difficult to engage. Perhaps service

providers themselves feel rejected by homeless people leading to a lack of engagement and being stuck in the precontemplation stage of 'can't change'.

For reasons of space, shared themes are reported rather than a list of individual themes too numerous and complex to present coherently and with value. The lack of individual accounts to come through may be seen as a limitation of this study. The participants provided rich material that is available for secondary analysis. The current study was concerned with presenting the findings to the overall question of the role of clinical psychology for homeless people.

### **Interview content**

To infer the role of clinical psychology participants were asked about their use of mental health services, rather than clinical psychology as such. Therefore a possible criticism of the study is that participants should have been asked about clinical psychology specifically. In practice, however, it was found that the pilot participants did not have a clear idea of clinical psychology as distinct from other mental health services. The pilot study participants had been aware of what mental health services were and therefore the researcher did not see a need to explain what clinical psychology was, especially as the role of clinical psychology was planned to be interpreted from the accounts. Any explanation may in practice only have served to lead participants to respond to demand characteristics of the situation rather than expressing in their own words what their mental health needs were. All main study participants had had experience of mental health services. For most this was directly for them, for Fred and Gary this was indirect contact through people they knew. Contact was usually with psychiatry, community psychiatric nurses and some contact with psychology or counselling. The researcher was confident that when asking specifically

about mental health services, all the participants knew what was meant and could say what their needs were.

### **Accuracy of accounts**

At times during the interviews the researcher was dubious about the accuracy of the homeless participants' accounts due to contradictory information and/or narratives that were perceived as an exaggeration about the individual's abilities. IPA methodology assumes that the individual will give their own perspective on experience that reflects their inner psychological world within a social context. Through interpretation, this process is open to examination by others. Some statements can reflect ambivalence that can be hard to interpret. The researcher collated examples of themes that were clear and inter-rater reliability was good. The focus of the study was the participants' subjective experience, and accounts, rather than objective facts *per se*.

These issues were less pertinent for the clinical psychologists who were asked a number of mainly closed questions about their working practices rather than their own personal experiences.

### **Design issues**

It could be suggested that a better research design would have been to recruit a large, representative sample and to use only standardised quantitative measures to gather relevant data. However, to look at stages for readiness to change or needs of homeless people within a quantitative design, the researcher would have had to develop measures and validate these within a population of homeless people as there are none available. The current study was not planned in such a way as to test hypotheses or to make comparisons with others. The role of clinical psychology for homeless people, if there was one, was not

clear from the literature review. Therefore a quantitative methodology for an exploratory, unknown area did not seem appropriate.

Typically qualitative methodologies are criticised for not providing causal links about psychological phenomena or being generalisable to other samples of the same population. However, the notions of causality and generalisability fall within a quantitative experimental approach that was not appropriate to the exploratory nature of this study. Discovering the detail of individual perceptions allows the researcher to extrapolate on the psychological processes operating on the participants' and to relate these to wider psychological theory, giving theoretical generalisation rather than statistical generalisation (Yin, 1994).

### **Reliability and validity**

The reliability and validity of the current study was checked using a number of criteria. The standardised measures used are reported to be reliable and valid and the semi-structured interview conducted within a user-designed approach had face validity.

The transparency of the current research process enables these findings to be transferred to future research (Guba & Lincoln, 1994) aided by the account of the research in the reflexive diary (Appendix 12). The emerging themes were checked by a second person and minor modifications were made before a third person took part in inter-rater reliability checks of the transcripts, all of which fell within the Cohen Kappa's range of  $\kappa = 0.90$ 's. In terms of coherence with other research findings, the current study supports the notion of a precontemplation stage of change (Prochaska & Prochaska, 1999) and supported challenges (Hinton, 1997; Snow & Anderson, 1987; Sumerlin & Norman, 1992) to Maslow's (1968) Hierarchy of Needs model.

### **Critique of methodology conclusions**

The criticisms of this study notwithstanding, most of the UK literature on homelessness is epidemiological. The current study moves away from this and investigates psychological phenomena in homeless men with mental health problems who use day/night shelters. This is the first UK study exploring the role of clinical psychology for homeless people with mental health problems. Therefore this study adds to the limited knowledge about the needs of homeless people with mental health problems and the role of clinical psychology for this population.

### **4.3 Implications for future research**

Engaging participants involved long periods of time hanging around, playing games, chatting informally and becoming involved in jobs around the day centres. Over a period of weeks the researcher got to know many more people than were interviewed. The researcher became distressed when two users in one day centre/night shelter (non-participants) were assaulted by other ex-users. Witnessing the impact of the violence of homeless life, led to the researcher ending recruitment and withdrawing from the service. Interestingly, this is the same coping strategy that most of the homeless participants used themselves.

Potential areas of future research arising from the current study include more rigorous or extensive studies to confirm or extend the conclusions reached especially of the tentative narrative account of the groups' experiences of homelessness, service provision, sense of themselves and coping skills. Although this study did not aim to be generalisable, the transparency of the research process should enable comparisons (where appropriate) with future work in this area.

Although equal numbers of participants mentioned themes of low self-esteem and being independent and able, that could be seen as a way of protecting the self from low self-esteem. There were many more examples of low self-esteem and negative views of the self within the interview data. The needs and aspirations of the homeless men implied that 'homed' people had jobs, could cope with life and had trusting and helpful relationships and that they as homeless people did not, and perhaps could not have the same. These identified needs are all known to be protective factors for both homelessness and mental health (Lehman, et al., 1995). If homeless people do not expect to have positive lifestyles then it is unlikely that they will seek help to have one.

Low self-esteem has been related to the generation and perpetuation of most psychopathology (Bandura, 1999) and most of this sample experienced significant psychopathology. This supports an association between low self-esteem and mental health difficulties. As there are few studies of the self-concept of homeless people, expectations and how these may maintain the homeless status, future research should address this issue.

One clinical psychologist thought that the length of time homeless had a significant impact on the likelihood of engagement. The identity management strategies of the homeless have begun to be looked at (Farrington & Robinson (1999). The idea of acculturation to homelessness and the implications for mental health and help seeking behaviour was not explored within this study. Kuhlman (1994) suggests that psychological intervention is much more likely to be successful when a person first becomes homeless because they still identify themselves as 'homed' rather than 'homeless' and are more likely to engage with services. These ideas have not been explored in depth and would complement future



research on the identity of homeless people and how this impacts on their experiences, particularly of help seeking behaviour.

None of the main study participants hinted or suggested that taking part would result in any tangible 'reward' and all agreed to be contacted again for feedback, suggesting that motivation to take part in this study was not influenced by immediate basic needs such as food or shelter. In addition, future researchers should not be hesitant in approaching people to take part in studies because of some degree of psychopathology.

#### **4.4 Clinical Implications**

A range of potential implications can be tentatively surmised from this study. It is clear that homeless men who use night shelters and who have slept rough are vulnerable to homelessness due to a range of factors that include the breakdown in relationships with parents or partners and mental health difficulties. Clinical Psychologists may want to pay particular attention to adolescents when devising preventative work, because for some people the first episode of homelessness followed on from friction with parents during adolescence.

The homeless men within this sample clearly identified needs beyond basic food and shelter. Wanting to build relationships and in some cases specifically wanting counselling or 'stress therapy' was mentioned, as was feeling excluded from services. Instead of employing clinical psychologists for the homeless, perpetuating a perception of exclusion, there is a need for clinical psychologists within mainstream service provision to provide more time to this client group.

Even with increased psychological resources in terms of the number of clinicians working in the field, the service provided would need to be acceptable to the homeless person.

Advertising psychology services, promoting its potential benefits and being where the homeless people are, i.e. in day centres, night shelters and hostels may improve the access to psychology services. During the literature review, one account of direct work with a client on the street was found (Harper, 1999). A psychodynamic approach was taken that probably raised the awareness of the need for change, thus fitting with the person's readiness to change.

An awareness that some people may find it difficult to talk about the past or future suggests that solution focused therapy or cognitive-behavioural models may be employed once a person has reached an awareness that they need or want to change. Before this psychodynamic techniques or perhaps motivational interviewing (Miller & Rollnick, 1991) may be more likely to facilitate this process as used by the clinical psychologists in this study.

The accounts given of contact with mental health services tended to be at points in time when the person was in a crisis. This may be an ideal time for psychologists to begin contact. Engaging through practical tasks in much the same way as described in Assertive Community Treatment Models may lead to facilitation of a direct psychological intervention (Johnsen et al., 1999). Cupitt (1997) discusses the role of the assertive outreach psychologist. The coping strategies that the homeless people engaged in tended to be avoidant suggesting that they are unlikely to actively procure help for their mental health needs. This suggests that engagement will be difficult. However, this is not a justification for not offering a service at all.

Deterioration of mental health may be avoided if the self-esteem needs of the homeless with mental health problems could be addressed at a service level. Having something to do was an identified need. Gary took part in a play whilst staying at a night shelter that made him feel good about himself and raised his expectations (that is, he wanted to do another play). Gary's GHQ-12 and BPRS scores were low and this might be at least partially due to his raised self-esteem through this activity. If self-esteem is raised, then the person might want to change, i.e. get food and shelter, build relationships and so on. Activity may be a point of entry in an otherwise vicious circle of low self-esteem – can't change.

Being exposed to violence directly or indirectly has implications for the physical and mental health of researchers and more importantly workers and clinician's who are likely to have prolonged exposure to such traumatic life events if they spend an appreciable amount of time in the setting. The provision of regular supervision, training and support to the worker are likely to be the best ways of dealing with such events.

The sense of isolation and lack of support that clinical psychologists feel working with this population needs to be addressed at a professional and service level. If service providers feel demoralised, they are not going to be able to provide the most effective service they could do otherwise (Prussia & Kinicki, 1996). Becoming integrated into mainstream service may help psychologists feel less isolated, rather than providing 'specialist' services to the homeless population. The Voluntary Sector services may be an untapped resource in terms of forming supportive networks within the homeless population. Increasing communication between statutory and voluntary organisations is likely to help service providers feel less isolated and overwhelmed by the demand.

#### **4.4.1 Local effects of taking part in the process of research**

One of the practical implications of the research is the effect that it has had on the participants and the services involved in the process of the study itself. All but one of the homeless participants were willing to be contacted again and wanted to know the outcome of the research, suggesting that they were fully engaged in the research process and valued the contribution they were able to make. At the start of the research only two of the clinical psychologist participants were in touch with one another and the author was able to begin a professional network by giving the contacts of each psychologist to each other (with their permission).

The local implications are part of an ongoing process. Individual feedback sessions with participants will provide a forum to explore the research findings with the participants themselves and discuss any results that they find surprising or unexpected. Similarly, the process of presenting the results to the Managers of the services where the participants were recruited and the clinical psychologist participants may lead to service development discussion. Both Managers had expressed a need and wish to develop psychological services within the centres and it is hoped that this study will support applications for funding. This process is a circular one. It is anticipated that information from these discussions will inform further areas of research.

#### **4.5 The role of clinical psychology for homeless people**

The role of clinical psychology for homeless people is potentially challenging and demanding, but most of all wanted. The nature of the work is likely to include a great deal of negativity, exposure to violence, entrenched low self-esteem and self destructiveness, yet people seem willing to engage if you take the service to them.

There is scope for the full range of psychological interventions discussed by Marzillier (1998). In terms of direct level interventions, one-off session interventions should be planned at least initially with the aim of engagement and promoting an awareness of a need for change. At this stage solution focused therapy, motivational interviewing and psychodynamic techniques are likely to be useful as these are the models used already within the field. Realistically, it is likely that clinical psychologists will opt for spending most time conducting indirect work such as consultancy, supervision, training and service development that is both valuable and consistent with the multiple skills clinical psychologists have to offer.

The presence of the clinical psychologist in outreach teams or in providing outreach within mainstream services is likely to promote the accessibility to psychological services. Working as part of a team is likely to protect the clinical psychologist from a sense of isolation. Seeking professional support from one's own profession and other team members is of importance in this work.

## **4.6 Conclusions**

This study is timely, given homelessness has gained the nation's attention and is now perceived as a major social issue. Most of the UK literature on homelessness is epidemiological. The current study moves away from this and investigates psychological phenomena from the homeless person's perspective. This is the first UK study exploring the role of clinical psychology for homeless people with mental health problems.

In conclusion a sample of homeless men with significant mental health difficulties who use day centres/night shelters identified a need and role for services that clinical psychologists are in an ideal position to provide. The men identified a need for direct therapeutic work that does not preclude the invaluable indirect level work already present in this field. The needs identified by the homeless men can be met through the use of a range of psychological intervention levels, models and strategies. Being homed is not a necessary precursor for psychological intervention.

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